

Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform

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I. INTRODUCTION

A majority of Americans receive health care under employee health care plans.¹ Employee health care plans and other employee welfare plans,² such as disability and life insurance plans, are governed by the Employee Retirement Income Security Act of 1974 (ERISA).³ The purpose of ERISA is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."⁴ Although this purpose is clear in the Act and its legislative history, judicial decisions have reshaped ERISA in far-reaching ways so that it now often serves as a shield for employers, insurance companies, and plan administrators, rather

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¹ In 1988, according to United States Census Bureau figures, 150.4 million Americans received their health care coverage from employee benefits plans. *See* BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 100 (1991).

² *See* Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, § 3(1), 88 Stat. 829, 833 (codified at 29 U.S.C. § 1002(1)). The terms "employee welfare benefit plan" or "welfare plan" include health care, accident, disability, death benefit, and other employee benefits plans. *See id.* In this Article, such plans are referred to generally as employee benefits plans.

³ 29 U.S.C. §§ 1001-1461 (1988 & Supp. V 1993). For a general introduction to ERISA, *see* RONALD J. COOKE, ERISA PRACTICE AND PROCEDURE (1993); HENRY H. PERRITT, JR., EMPLOYEE BENEFITS CLAIMS LAW AND PRACTICE (1990); Jay Conison, *Foundations of the Common Law of Plans*, 41 DEPAUL L. REV. 575 (1992).

⁴ 29 U.S.C. § 1001(b).

than to protect participants' rights.⁵ The extent to which ERISA now serves the converse of its original purpose is suggested by the advice one commentator has given to lawyers defending benefits plans against participants' claims: "On issues ranging from punitive and extracontractual damages to jury trials, the 'ERISA Umbrella' offers a wealth of strategic advantages in defending insurers against claims of improper administration of employee benefit plans."⁶

This Article reviews the principal judicial decisions that have transformed ERISA into a defendants' shield and suggests the practical consequences that these decisions have had on the ability of ERISA-plan participants and beneficiaries to develop successfully their claims for health care, disability, and other employee benefits.⁷ The Article then examines current legislative efforts to protect health care claimants, including those proposals made as part of general health care reform.⁸ The Article concludes by identifying the principal elements of meaningful reform—reform that is necessary if ERISA's promise of protection for participants in employee benefits plans is to be realized.⁹

II. THE SETTING

It is a period of "tumultuous economic, social and political changes shaking the worlds of health care and insurance."¹⁰ The cost of health care in the United States more than doubled during the 1980s¹¹ and continues to grow

⁵ Recently, in *Mertens v. Hewitt Associates*, 113 S. Ct. 2063 (1993), Justice White, joined in dissent by Chief Justice Rehnquist and Justices Stevens and O'Connor, wrote that the Court was interpreting ERISA § 502(a)(3) to "deprive beneficiaries of remedies they enjoyed prior to the statute's enactment." *Id.* at 2078 (White, J., dissenting). For a valuable discussion of the degree to which the original purposes of ERISA have been undercut, see William K. Carr & Robert L. Liebross, *Wrongs Without Rights: The Need for a Strong Federal Common Law of ERISA*, 4 STAN. L. & POL'Y REV. 221 (1993). "Employees frequently are cheated out of employer-provided pension, health insurance, and severance pay benefits. The reason is simple: the courts do not construe the law to protect them." *Id.* at 221.

⁶ James L. Nolan & Eunice L. Bumgardner, *Defending the Insurance Company Against Claims for Wrongful Denial in Administration of Employee Benefits Plans*, ALI-ABA Course of Study, Jan. 16, 1992, available in WESTLAW, C719 ALI-ABA 129, at 169.

⁷ See *infra* parts III–V.

⁸ See *infra* part VI.

⁹ See *infra* part VII.

¹⁰ Robert Pear, *Leading Health Insurers into a New Age*, N.Y. TIMES, Dec. 6, 1992, § 3, at 11.

¹¹ In 1980, \$249.1 billion was spent on health care; by 1989, this figure had reached \$604.1 billion. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, *supra* note 1, at 92.

at a rate that is said to threaten the nation's economy.¹² Employers, faced with paying a large part of the bill, increasingly have demanded controls on rising insurance costs, and insurers have responded by instituting an array of cost containment mechanisms.¹³ These mechanisms include utilization review and managed care procedures under which physicians' treatment decisions are reviewed by insurance companies or independent utilization review companies.¹⁴ Such reviews often lead to disagreement about the appropriateness or necessity of medical care.¹⁵ Disputes arise about issues like

¹² Robert Pear, *Health-Care Costs Up Sharply Again, Posing New Threat*, N.Y. TIMES, Jan. 5, 1993, at A1, A10. The Department of Commerce reported that \$942.5 billion was spent on health care in 1993 and that the figure will rise to \$1.06 trillion in 1994. Robert Pear, *\$1 Trillion in Health Costs Is Predicted*, N.Y. TIMES, Dec. 29, 1993, at A12.

¹³ See Mary R. Kohler, Note, *When the Whole Exceeds the Sum of Its Parts: Why Existing Utilization Management Practices Don't Measure Up*, 53 U. PITT. L. REV. 1061, 1098 (1992).

Government, business, insurers, institutional providers such as hospitals and health maintenance organizations, and virtually everyone else with a major financial stake in health care now control their resources with a striking array of cost-containment and profit-producing measures, ranging from managed care and intensive utilization review to caps on coverage and restrictions on eligibility.

E. Haavi Morreim, *Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 ARCHIVES INTERNAL MED. 443, 444 (1991).

¹⁴ See, e.g., Thomas M. Burton, *Firms That Promise Lower Medical Bills May Increase Them*, WALL ST. J., July 28, 1992, at A1, A9.

[Utilization review] firms have become immensely popular with employers seeking to control their health-care costs. According to a survey conducted by trade publisher Faulkner & Gray Inc., U.S. employers and insurance companies this year alone will pay an estimated \$7 billion to have their medical expenses reviewed. Utilization review firms perform that service by questioning the necessity both of recommended treatment and treatment already administered.

Id. at A1. See generally John Iglehart, *The American Health Care System: Managed Care*, 327 NEW ENG. J. MED. 742 (1992); Arnold S. Relman, *Controlling Costs by "Managed Competition": Would It Work?*, 328 NEW ENG. J. MED. 133 (1993).

¹⁵ See, e.g., Lisa Belkin, *Under New Health Plans, Patients Change Habits*, N.Y. TIMES, Jan. 6, 1993, at A1, B2; Milt Freudenheim, *The Physicians' View When Managed Care Comes to Town*, N.Y. TIMES, June 14, 1992, § 3, at 4; Gina Kolata, *When Doctors Say Yes and Insurers No*, N.Y. TIMES, Aug. 16, 1992, § 3, at 1, 6; Elisabeth Rosenthal, *Insurers Second-Guess Doctors, Provoking Debate over Savings*, N.Y. TIMES, Jan. 24, 1993, at A1.

the proper length of a hospital stay, the medical necessity of services such as nursing care, and the experimental nature of a particular treatment. Protracted delays in approving or disapproving recommended treatment can occur.¹⁶

In another effort at cost control, a growing majority of the nation's largest employers now self-insure against the health care claims of their employees.¹⁷ Under ERISA, such self-insured health care plans escape all state laws regulating insurance companies.¹⁸ Self-insurance by large employers and other changes in the health insurance market have led to increased competition among insurance companies.¹⁹

Finally, during the 103d Congress, various sponsors including President Clinton proposed complex plans to revamp the nation's health care system.²⁰ These efforts at health care reform gave rise to unprecedented lobbying and media campaigns by insurance companies and insurance industry organizations, physicians and hospital groups, corporations and business groups, and public interest and consumer groups. Congressional debate became factionalized and highly partisan, grinding to a halt under threats of filibuster without a vote in either the Senate or House of Representatives on any of the reform proposals.²¹

¹⁶ See Burton, *supra* note 14, at A9.

¹⁷ EMPLOYER HEALTH CARE COST CONTAINMENT 15 (Jon Liebman ed.) (Leonard Davis Inst. of Health Economics, Univ. of Pa., Factpack Series No. 10, 1986); Dale A. Rublee, *Self-Funded Health Benefit Plans*, 255 JAMA 787, 790 (1986). "Disputes over claims have become more frequent as [self-insured] employers and health plans try to curb costs by refusing to pay for certain medical tests, devices and procedures that doctors say are necessary." Robert Pear, *State Regulators Seek Power over Self-Insured Employers*, N.Y. TIMES, Sept. 21, 1994, at B7.

¹⁸ See *infra* part III.C.

¹⁹ See, e.g., Milt Freudenheim, *The Unquiet Future of Commercial Health Insurance*, N.Y. TIMES, July 12, 1992, § 3, at 11; John K. Iglehart, *The American Health Care System: Private Insurance Health Policy Report*, 326 NEW ENG. J. MED. 1715, 1716 (1992); Wendy K. Mariner, *Problems with Employer-Provided Health Insurance: The Employee Retirement Income Security Act and Health Care Reform*, 327 NEW ENG. J. MED. 1682, 1684 (1992).

²⁰ See, e.g., H.R. 3600, 103d Cong., 2d Sess. (1993), and S. 1757, 103d Cong., 2d Sess. (1993) (President Clinton's Health Security Act); H.R. 1200, 103d Cong., 1st Sess. (1993), and S. 491, 103d Cong., 1st Sess. (1993) (McDermott-Wellstone American Health Security Act of 1993); H.R. 3080, 103d Cong., 2d Sess. (1993), and S. 1533, 103d Cong., 1st Sess. (1993) (Michel-Lott Affordable Health Care Now Act of 1993); H.R. 3222, 103d Cong., 2d Sess. (1993), and S. 1579, 103d Cong., 1st Sess. (1993) (Cooper-Breaux Managed Competition Act of 1993); H.R. 3704, 103d Cong., 2d Sess. (1993), and S. 1770, 103d Cong., 2d Sess. (1993) (Thomas-Chafee Health Equity and Access Reform Today Act of 1993).

²¹ See Adam Clymer, *National Health Program, President's Greatest Goal, Declared Dead in Congress*, N.Y. TIMES, Sept. 27, 1994, at A1, B10; *Why Health Care Fizzled: Too*

For the immediate future, congressional impasse may shift some of the health care debate to state legislatures,²² but the insurance and health care problems that stirred such heightened nationwide controversy in 1993 and 1994 are not likely to disappear. In the words of one observer, "[T]he whole noisy, confusing, troubling, expensive health care struggle will almost certainly end up back in Washington."²³

This is the troubled context in which the rights of health care claimants under ERISA must be analyzed.

III. PREEMPTION OF PROTECTIONS AGAINST BAD FAITH AND UNFAIR CLAIMS PRACTICES

Historically, and particularly since the enactment of the McCarran-Ferguson Act,²⁴ regulation of the business of insurance has been left to the states. When fashioning a preemption clause in ERISA, Congress seemed careful not to create the regulatory void that would arise if ERISA were to preempt state regulation of insurance. Although the preemption clause in ERISA is sweeping—the Act supersedes “any and all State laws insofar as they

Little Time and Too Much Politics, N.Y. TIMES, Sept. 27, 1994, at B11.

²² See Milt Freudenheim, *Insurance Companies Expect Battle over Health Care to Shift to the States*, N.Y. TIMES, Oct. 23, 1994, § 1, at 22; *State Officials Strive to Bring the Health Care Debate Home*, N.Y. TIMES, Sept. 25, 1994, § 1, at 30.

²³ Robin Toner, *Ills of Health System Outlive Debate on Care*, N.Y. TIMES, Oct. 2, 1994, § 4, at 1, 4.

If the Federal Government does not restructure the health care system this year, . . . experts say, it only means that the system will continue to be restructured piecemeal by employers and massive insurance companies and managed care networks. If Congress cannot reach a consensus on how to regulate these changes, and deal with some of the problems of cost and coverage, it only means that the pressure will grow on the states to do so, piecemeal—which means the chorus may rise once again for uniform Federal laws.

Id. at 1.

²⁴ In 1868, the Supreme Court held that the business of insurance is not commerce within the meaning of the Commerce Clause of the United States Constitution, leaving the federal government without a basis for regulating insurance companies. See *Paul v. Virginia*, 75 U.S. 168, 183 (1868). This decision was overturned by *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), but shortly thereafter, Congress enacted the McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (1988)).

may now or hereafter relate to any employee benefit plan"²⁵—with respect to insurance, Congress expressly limited ERISA preemption by providing in the so-called saving clause: "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance" ²⁶ State law is defined to include "all laws, decisions, rules, regulations, or other State action having the effect of law."²⁷ Limiting the sweep of ERISA preemption is consistent with the McCarran-Ferguson Act. Section 2 of that Act provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance" ²⁸ The legislative effort to preserve state regulation of insurance has been undercut by judicial decisions preempting state common law actions against insurers, preempting actions based on state unfair insurance practices statutes, preempting state regulation of self-insured benefits plans, and preempting actions based on wrongful insurer utilization review practices.

A. Preemption of State Common Law Actions

The apparent congressional purpose of saving all state law regulating insurance, including state decisional law, was frustrated by the Supreme Court's decision in *Pilot Life Insurance Co. v. Dedeaux*.²⁹ In *Pilot Life*, the Court held that an action based on Mississippi law for wrongful handling of an insurance claim was preempted by ERISA.³⁰ The adverse effect of this decision for ERISA participants has been the nullification of an important body of state law regulating insurance—state decisional law providing protections against the improper processing of insurance claims.

Before the advent of insurance bad faith law, in an action against an insurer for the wrongful denial of a claim, damages were limited to the amount due under the insurance contract. Under this rule, the greatest risk faced by an insurer in delaying or denying a claim was a judgment requiring payment of the amount due under the contract. Beginning in 1973, a growing number of state

²⁵ 29 U.S.C. § 1144(a).

²⁶ *Id.* § 1144(b)(2)(A).

²⁷ *Id.* § 1144(c)(1).

²⁸ 15 U.S.C. § 1012(b) (1988). For an informative introduction to the history and interpretation of the ERISA preemption clause, see Daniel M. Fox & Daniel C. Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. HEALTH POL., POL'Y & L. 239 (1989).

²⁹ 481 U.S. 41 (1987).

³⁰ *Id.* at 57.

courts, and now a clear majority, have allowed actions against insurance companies for the mishandling of first-party, non-ERISA, insurance claims.³¹ Recognition of such actions began with the decision of the California Supreme Court in *Gruenberg v. Aetna Insurance Co.*³² In *Gruenberg*, the court held: "[W]hen the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort."³³

In *Pilot Life*, the plaintiff brought several state law claims, including a bad faith claim,³⁴ against the insurer, which provided an employment-related, long-term disability plan. The plaintiff alleged wrongful mishandling of his disability claim and sought damages for failure to provide benefits under the insurance policy, general damages for mental and emotional distress, and punitive damages.³⁵ The Supreme Court held that the plaintiff's state law claims against the insurer were preempted by ERISA.³⁶

This ruling distorts the relationship between ERISA-plan claimants and insurance companies underwriting ERISA benefits plans. Preemption of state law bad faith claims not only deprives claimants of compensation for consequential harm and eliminates deterrence of bad faith conduct on the part of insurance companies, but preemption of bad faith claims also makes it economically rational for insurance companies to delay or deny payment of claims because there is no cost to fear from doing so. In the words of a congressional report:

[L]ittle financial downside exists for an insurance company that routinely delays payment or refuses to pay large claims. . . . [E]ven if a suit is brought and the court finds that the insurance company has behaved in the most egregious and outrageous way, the worst that could happen to the insurance company is that it would be forced to pay the claim it should have paid in the

³¹ See STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES §§ 2:10-:15 (rev. ed. 1992 & Supp. 1994); see also PROPERTY INSURANCE LAW COMMITTEE, ABA TORT AND INSURANCE PRACTICE SECTION, BAD FAITH AND PUNITIVE DAMAGES: ANNOTATIONS TO FIRST-PARTY INSURANCE CASES, STATUTES, AND REGULATIONS (1986 & Supp. 1993).

³² 510 P.2d 1032 (Cal. 1973).

³³ *Id.* at 1038.

³⁴ In *Blue Cross & Blue Shield of Mississippi, Inc. v. Campbell*, 466 So. 2d 833 (Miss. 1985), the Mississippi Supreme Court stated: "We have come to term an insurance carrier which refuses to pay a claim when there is no reasonably arguable basis to deny it as acting in 'bad faith,' and a lawsuit based upon such an arbitrary refusal as a 'bad faith' cause of action." *Id.* at 842 (denying rehearing).

³⁵ *Pilot Life*, 481 U.S. at 43-44.

³⁶ *Id.* at 57.

first place.³⁷

The *Pilot Life* decision has made fair settlement of claims impossible for ERISA-plan claimants. With an insurance company's exposure limited to the amount of benefits payable under the policy, it can maintain an inflexible negotiating posture, confident that it will pay less than its full-coverage obligations in all disputes that are ultimately settled, as most must be. By maintaining an uncompromising negotiating position, the insurance company retains its funds, exhausts plaintiffs' resources, and spreads word to the plaintiffs' bar that ERISA-plan claimants simply cannot win, discouraging the bringing of other suits.³⁸

The *Pilot Life* decision has had consequences more far-reaching than the preemption of common law bad faith claims. In the first part of the opinion, the Court examined ERISA's express preemption clause³⁹ and found plaintiff's claims preempted by applying the analysis set forth in *Metropolitan Life Insurance Co. v. Massachusetts*.⁴⁰ Perhaps recognizing that this analysis gave

³⁷ H.R. REP. NO. 1023, 102d Cong., 2d Sess. 23-24 (1992).

³⁸ For testimony regarding the consequences of *Pilot Life* for ERISA welfare benefits claims, see *Bills Relating to ERISA's Preemption of Certain State Laws: Hearings on H.R. 1602 and H.R. 2782 Before the Subcomm. on Labor-Management Relations of the House Comm. on Education and Labor*, 102d Cong., 1st Sess. (1991); see also Carr & Liebross, *supra* note 5, at 223-24; Robert L. Aldisert, Note, *Blind Faith Conquers Bad Faith: Only Congress Can Save Us After Pilot Life Insurance Co. v. Dedeaux*, 21 LOY. L.A. L. REV. 1343, 1347 (1988). For discussion of the effect of ERISA preemption on health care provider misrepresentation claims, see Jeffrey A. Brauch, *Health Care Providers Meet ERISA: Are Provider Claims for Misrepresentation of Coverage Preempted?*, 20 PEPP. L. REV. 497 (1993). Several courts have held that, unlike participants' or beneficiaries' claims, health care providers' state law claims against insurers or plan administrators are not preempted by ERISA. See, e.g., *Lordmann Ents., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1532-34 (11th Cir. 1994); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752, 753-56 (10th Cir. 1991); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243-50 (5th Cir. 1990).

³⁹ 29 U.S.C. § 1144(a).

⁴⁰ 471 U.S. 724 (1985). In *Metropolitan Life*, the Court held that, as applied to insurance policies purchased by employee health care plans regulated by ERISA, a Massachusetts statute requiring minimum mental health care benefits was not preempted by ERISA, because the state statute was saved as a law that regulates insurance.

In *Pilot Life*, the Court drew upon the *Metropolitan Life* analysis first by finding that plaintiff's common law causes of action based upon state law of bad faith "relate to" an employee benefits plan and, therefore, fall under ERISA's express preemption clause unless the state law of bad faith is saved as a law "which regulates insurance." *Pilot Life*, 481 U.S. at 47-48. The Court then conducted a two-fold inquiry to determine whether the state bad faith law "regulates insurance." The Court first took what it called a "common-sense view"

weak support to the conclusion that the Mississippi law of bad faith was expressly preempted, the Court went on to articulate a second, much broader ground for its decision—implied preemption based upon ERISA’s civil enforcement provision, section 502(a) of the Act.⁴¹ In the Court’s view, the

of the language of the saving clause and made the assertion, by no means self-evident, that “[a] common-sense view of the word ‘regulates’ would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.” *Id.* at 50. Then the Court applied the remaining consideration drawn from *Metropolitan Life*, examining whether the state law of bad faith met the criteria used to identify the “business of insurance” under the McCarran-Ferguson Act. In cases under the McCarran-Ferguson Act, the Court had employed the following criteria to determine whether a particular practice falls within the Act’s reference to the “business of insurance,” which the states were empowered to regulate: (1) whether a practice had the effect of transferring or spreading a policyholder’s risk; (2) whether a practice was an integral part of the policy relationship between the insurer and the insured; and (3) whether a practice is limited to entities within the insurance industry. *Id.* at 50–51. The Court concluded that consideration of these criteria did not support the assertion that the Mississippi law of bad faith “regulates insurance.” *Id.*

⁴¹ Section § 502(a) provides:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section [relief relating to requests to the plan administrator for information], or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [relating to breach of fiduciary duty];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title [relating to information to be furnished to participants];

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

provisions of section 502(a) set forth a "comprehensive civil enforcement scheme."⁴² According to the Court, the care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in the choice of remedies implied that ERISA's civil enforcement remedies were intended to be exclusive.⁴³

The Court's finding in *Pilot Life* of an implied basis for preemption of state law despite an express preemption provision is inconsistent with the Court's more recent analysis of preemption in *Cipollone v. Liggett Group, Inc.*⁴⁴ In *Cipollone*, the Court concluded that, when Congress has considered the issue of preemption and has included in the legislation a provision explicitly addressing the issue, there is no need to infer congressional intent from other provisions of the legislation: "Congress' enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted."⁴⁵ If this principle had been applied in *Pilot Life*, the Court would not have gone beyond analysis of the express preemption provisions to infer congressional intent that ERISA's civil enforcement scheme be exclusive. By incorporating the broader, exclusive-remedy analysis in *Pilot Life*, however, the Court has influenced other courts to hold that, even when state law "regulates insurance" and therefore fits squarely within the saving clause of the

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title [relating to information necessary to comply with Medicare and Medicaid Coverage Data Bank requirements], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. § 1132(a) (as amended by the Pension Annuity Protection Act of 1994, Pub. L. No. 103-401, 108 Stat. 4172).

⁴² *Pilot Life*, 481 U.S. at 54.

⁴³ *Id.*

⁴⁴ 112 S. Ct. 2608 (1992). In *Cipollone*, the Court considered whether federal statutes requiring warning labels on cigarette packages preempted plaintiff's common law claims against various cigarette manufacturers. For an analysis of *Cipollone*, see *The Supreme Court—Leading Cases*, 106 HARV. L. REV. 163, 347-57 (1992).

⁴⁵ *Cipollone*, 112 S. Ct. at 2618.

ERISA preemption provisions, a state law remedy based on such law will nevertheless be preempted impliedly because Congress intended ERISA's civil enforcement scheme to be exclusive.⁴⁶

B. *Preemption of State Statutory Actions*

The implied-preemption analysis in *Pilot Life* has encouraged courts to dismiss actions by ERISA-plan claimants that are based on state unfair insurance claim settlement statutes.

In 1971, the National Association of Insurance Commissioners promulgated amendments to its model act,⁴⁷ specifically defining a variety of unfair claim settlement practices.⁴⁸ Forty-three states have enacted or adopted versions of these amendments in their laws regulating insurance companies.⁴⁹ Generally, the specified unfair claim settlement practices are similar to the types of insurance company practices that would support common law bad faith actions. The specified unfair practices include "misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue"; "refusing to pay claims without conducting a reasonable investigation based upon all available information"; and "not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear."⁵⁰ A number of states have allowed private actions under such unfair claim settlement practices statutes.⁵¹

Following *Pilot Life*, various courts have had to consider whether private actions under state unfair claim settlement statutes might be saved from

⁴⁶ See *infra* part III.B.

⁴⁷ AN ACT RELATING TO UNFAIR METHODS OF COMPETITION AND UNFAIR AND DECEPTIVE ACTS AND PRACTICES IN THE BUSINESS OF INSURANCE (Nat'l Ass'n Ins. Comm'rs 1985) [hereinafter MODEL ACT], reprinted in ASHLEY, *supra* note 31, app. I.

⁴⁸ Believers in the inherent goodness of human nature might perceive the commissioners' 1971 amendments to the model act as a manifestation of their deep concern for insurance consumers. Skeptics, however, might regard as noteworthy the fact that at the same time there were four bills pending in Congress to give the Federal Trade Commission enforcement powers against insurance companies, that claim-related complaints had increased at an unprecedented rate, and that the insurance commissioners have rarely exercised their new statutory powers to protect insurance consumers from unfair claim settlement practices.

ASHLEY, *supra* note 31, § 9:02 (footnotes omitted).

⁴⁹ *Id.*

⁵⁰ MODEL ACT, *supra* note 47, §§ 4(9)(a), (d), (f).

⁵¹ See ASHLEY, *supra* note 31, § 9:03.

preemption even though state common law claims are preempted. In *Goodrich v. General Telephone Co.*,⁵² a California appellate court distinguished *Pilot Life*, holding that ERISA does not preempt a claim for damages under the unfair claim settlement practices provisions⁵³ of the California Insurance Code.⁵⁴ However, *Goodrich* was overruled by the California Supreme Court in *Commercial Life Insurance Co. v. Superior Court*.⁵⁵ The court concluded that *Pilot Life*'s teaching that Congress intended the remedies set forth in ERISA to be exclusive was controlling, and held that ERISA preempts private causes of action under the state insurance code.⁵⁶

⁵² 241 Cal. Rptr. 640 (1987), *overruled by* *Commercial Life Ins. Co. v. Superior Court*, 764 P.2d 1059 (Cal. 1988).

⁵³ CAL. INS. CODE § 790.03(h) (West Supp. 1993).

⁵⁴ In a carefully reasoned opinion, the court found that the relevant section of the state insurance code squarely met the criteria for a law that "regulates insurance" set forth in *Pilot Life*. The court acknowledged that upholding a private cause of action under the insurance code would be inconsistent with the finding in *Pilot Life* that the civil enforcement provisions of ERISA are exclusive. However, the court stated:

This inconsistency is not of our making. Rather it is the inevitable result of inherently inconsistent goals expressed in the ERISA preemption provisions. On one hand Congress expressed the intent to establish a uniform federal common law of rights and obligations under ERISA. Yet on the other hand Congress recognized the long-standing policy of deference to state regulation of insurance. Congress reaffirmed this deference twice in ERISA: once in the insurance savings clause (sec. 1144(b)) and again in section 1144(d) which prevents ERISA from being construed to "impair or supersede any law of the United States" including the McCarran-Ferguson Act.

Goodrich, 241 Cal. Rptr. at 647 (citing *Pilot Life*) (citation omitted).

⁵⁵ 764 P.2d 1059 (Cal. 1988).

⁵⁶ *Id.* at 1065-66. Justice Mosk wrote a sharp dissent, criticizing the "common sense" analysis in *Pilot Life* and commenting generally about preemption:

There is a growing and ominous trend toward federal preemption of issues that belong within the sphere of control by the individual states. And these inroads into traditional federalism are taking place despite their inconsistency with pious rhetoric emanating from Washington about returning government to the people at state and local levels.

Id. at 1069 (Mosk, J., dissenting); *see also* *Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 96, 99-101 (9th Cir. 1988) (per curiam) (similarly concluding that *Pilot Life*'s preemption holding prevented an ERISA-plan claimant from bringing a private action for improper claims processing under the state insurance code), *cert. denied*, 492 U.S. 906 (1989).

C. Preemption of State Regulation of Self-Insured Plans

After *Pilot Life*, the Supreme Court decided another preemption case, which further undercut the states' ability to regulate benefits plans governed by ERISA. In *FMC Corp. v. Holliday*,⁵⁷ the Supreme Court considered the effect of ERISA preemption provisions upon a Pennsylvania state law that prohibited employee benefits plans from exercising subrogation rights against a claimant's tort recovery.⁵⁸ The ERISA plan in question was a self-funded, or self-insured, health care plan: the employer did not purchase insurance to provide the health care benefits. In recent years, a substantial majority of large employers have converted their health care plans from insurance-based plans to self-insured plans.⁵⁹ Because the health care coverage of a growing majority of Americans is provided by such self-insured plans, the question of whether such plans are subject to state regulation is of broad import.

As in *Pilot Life*, the Court in *Holliday* was called upon to apply the provisions of the preemption clause, section 514(a) of ERISA.⁶⁰ The Court first determined that the state statute was not preempted, because it fell within the insurance saving clause, section 514(b)(2)(A), which provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."⁶¹ The Court then considered the effect of the so-called deemer clause, section 514(b)(2)(B):

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.⁶²

The Court read the deemer clause to exempt self-funded ERISA plans from state laws that regulate insurance within the meaning of the saving clause.⁶³ "Our decision," the Court acknowledged, "'results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation

⁵⁷ 498 U.S. 52 (1990). For a careful analysis of *Holliday*, see James R. Bruner, Note, *AIDS and ERISA Preemption: The Double Threat*, 41 DUKE L.J. 1115, 1132-56 (1992).

⁵⁸ *Holliday*, 498 U.S. at 54.

⁵⁹ See *supra* note 17.

⁶⁰ 29 U.S.C. § 1144(a).

⁶¹ *Id.* § 1144(b)(2)(A).

⁶² *Id.* § 1144(b)(2)(B).

⁶³ *Holliday*, 498 U.S. at 61.

while the latter are not.”⁶⁴ In dissent, Justice Stevens said: “The Court’s construction of the statute draws a broad and illogical distinction between benefit plans that are funded by the employer (self-insured plans) and those that are insured by regulated insurance companies (insured plans).”⁶⁵ Justice Stevens offered an alternate reading of the deemer clause that would not preempt the state statute.⁶⁶

Both the majority’s and the dissent’s readings of the deemer clause have been criticized,⁶⁷ but congressional action seems required to alter the effect of *Holliday*.⁶⁸ As the law stands following *Holliday*, employers can avoid any state insurance regulation by changing from insurance-based health plans to self-insured health plans. As one commentator has observed: “ERISA, adopted almost twenty years ago to protect employees, now allows employers to enter what is, in effect, a regulation-free zone.”⁶⁹ The implications of the current

⁶⁴ *Id.* at 62 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)).

⁶⁵ *Id.* at 65 (Stevens, J., dissenting).

⁶⁶ *Id.* at 72 (Stevens, J., dissenting).

⁶⁷ See, e.g., Bruner, *supra* note 57, at 1144–48. Bruner suggests: “[A] more plausible interpretation of the deemer clause is that it prohibits states from regulating ERISA plans through any pretextual laws. . . . [T]he deemer clause should be interpreted to preempt *all* laws that merely purport to regulate insurance companies or insurance contracts, but are, in fact, aimed at something else.” *Id.* at 1153.

⁶⁸ The nation’s state insurance commissioners have recently called for amendment of ERISA to permit them to monitor the financial condition and claims practices of self-insured employers. See Robert Pear, *State Regulators Seek Power over Self-Insured Employers*, N.Y. TIMES, Sept. 21, 1994, at B7. The National Association of Insurance Commissioners, which represents insurance regulators from the fifty states, said that people in self-insured health care plans “enjoy fewer protections” than people with health care plans subject to state regulation. *Id.* Fred C. Nepple, chief counsel for the Wisconsin Insurance Department, said:

Under Erisa . . . there is no regulatory process to deal with unfair claims decisions or managed care practices. The administrators of these plans know we cannot audit them or review their files to see if there is a pattern of inappropriate denial of claims. We try to mediate, but have no authority.

Id.

⁶⁹ Alan I. Widiss & Larry Gostin, *What’s Wrong with the ERISA “Vacuum”? The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage Is To Be Provided When Risk Retention Plans Are Established for Health Care*, 41 DRAKE L. REV. 635, 654–55 (1992); see also Julie K. Swedback, Note, *The Deemer Clause: A Legislative Savior for Self-Funded Health Insurance Plans Under the Employee Retirement Income Security Act of 1974*, 18 WM.

state of the law were dramatically underscored in *McGann v. H & H Music Co.*⁷⁰ In that case, shortly after learning that an employee was being treated for AIDS, an employer changed from an insured health care plan to a self-insured plan and reduced the lifetime maximum benefits for AIDS-related claims from \$1,000,000 to \$5,000. All the state law claims were dismissed by the trial court, and dismissal of the discrimination claims under ERISA was upheld on appeal.⁷¹

D. Preemption of Remedies Against Wrongful Utilization Review Practices

The effort to contain health care costs has led employers and insurers to develop aggressive utilization review procedures.⁷² Utilization review involves the evaluation by an insurer, self-insured plan, or contracting agent of the appropriateness of medical treatment recommended by an attending or treating physician.⁷³ ERISA has been held to preempt state law remedies for negligent or abusive utilization review procedures. In *Corcoran v. United HealthCare, Inc.*,⁷⁴ for example, the court held that ERISA preempted a medical

MITCHELL L. REV. 757 (1992).

⁷⁰ 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992).

⁷¹ *Id.* at 404–08. For a careful analysis of the threat to sound health care policy from cases like *McGann*, see Widiss & Gostin, *supra* note 69. Claims similar to those presented in *McGann* may be raised under the Americans with Disabilities Act. *See, e.g.,* Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n of New Eng., Inc., No. 93-1954, 1994 WL 543530 (1st Cir. Oct. 12, 1994). For discussion of the effect of ERISA preemption on the health care benefits of people with AIDS and discussion of the Equal Employment Opportunity Commission's interim guidelines regarding insurance discrimination under the Americans with Disabilities Act, see Kathlynn L. Butler, Comment, *Securing Employee Health Benefits Through ERISA and the ADA*, 42 EMORY L.J. 1197 (1993); Lizzette Palmer, Comment, *ERISA Preemption and Its Effects on Capping the Health Benefits of Individuals with AIDS: A Demonstration of Why the United States Health and Insurance Systems Require Substantial Reform*, 30 HOUS. L. REV. 1347 (1993). Laura J. Schacht, Note, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act*, 45 WASH. U. J. URB. & CONTEMP. L. 303 (1994).

⁷² *See supra* notes 13–16 and accompanying text. *See generally* John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191 (1989); Elisabeth Rosenthal, *Insurers Second-Guess Doctors, Provoking Debate over Savings*, N.Y. TIMES, Jan. 24, 1993, at A1.

⁷³ *See* Blum, *supra* note 72, at 192–93.

⁷⁴ 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). For a helpful analysis of the case, see H.R. Scheel, Recent Development, *Corcoran v. United HealthCare, Inc.*:

malpractice action by the parents of an unborn child who died after the utilization review consultant for a disability plan, over the objection of the treating physician and another specialist, advised that the mother did not require bed rest during the final months of her pregnancy. The court, however, was troubled by the result, which it said "ERISA compels us to reach."⁷⁵ The court noted in particular that ERISA preemption eliminates "an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system."⁷⁶ In the analysis of one commentator, ERISA preemption is eliminating deterrence of wrongful utilization review practices.⁷⁷ "Under the Supreme Court's interpretation of ERISA remedies and preemption, the parties who institute aggressive UR programs are becoming increasingly immune from liability in their efforts to contain costs"⁷⁸

IV. DENIAL OF MAKE-WHOLE RELIEF UNDER ERISA

Because judicial decisions have ruled out claims based on other sources of law, ERISA-plan participants must look exclusively to ERISA for relief from improper processing or denial of health care and other employee benefits claims. Here too, the courts have taken a narrow view of the relief available.

ERISA Preemption of a Louisiana Tort Action, 67 TUL. L. REV. 821 (1993). See also Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc., 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 114 S. Ct. 694 (1994); Dukes v. United States Health Care Sys. of Pa., Inc., 848 F. Supp. 39 (E.D. Pa. 1994); Ricci v. Gooberman, 840 F. Supp. 316 (D.N.J. 1993).

⁷⁵ *Corcoran*, 965 F.2d at 1338.

⁷⁶ *Id.*

⁷⁷ See Kohler, *supra* note 13, at 1097.

If, under the current law, employers and insurers may raise ERISA preemption defenses, the legal system will lose its deterrent effect because ERISA's remedial bite is limited to an assessment for payment of erroneously denied benefits. The courts are sending a clear message to third party payors that they may employ aggressive UR practices without much fear of the consequences. If payment of erroneously denied benefits is the worst possible result, third party payors have little incentive to curb aggressive UR practices. An employer may negotiate the cheapest deal, reduce the price of his premiums, and pay the bills of those who complain. An individual injured in the process is stripped of his traditional common law remedies simply because he is "fortunate" enough to be the beneficiary of such an employee benefit agreement.

Id. at 1097-98.

⁷⁸ *Id.* at 1098. See generally David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861 (1991).

Section 502(a) of ERISA⁷⁹ sets forth what the Supreme Court in *Pilot Life* called a “comprehensive civil enforcement scheme.”⁸⁰ For ERISA participants or beneficiaries, three subsections of section 502(a) provide the principal means for enforcement of their rights under ERISA plans. These subsections provide for recovery of benefits due,⁸¹ remedies to protect a plan,⁸² and “other appropriate equitable relief.”⁸³

A. *Recovery of Benefits Due*

Section 502(a)(1)(B) provides that a participant or beneficiary may bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”⁸⁴ This provision is the basis for suits by ERISA-plan claimants to recover “benefits due” from a benefits plan; however, on its face, the provision limits recovery to the amount of benefits wrongfully withheld, and this limitation has been upheld in actions seeking compensatory and punitive damages.⁸⁵ Thus, this provision fails to provide any remedy for unreasonable delay, wrongful benefits denial, fraud, malice, or resulting harm to participants or beneficiaries.

B. *Remedies to Protect a Plan*

Section 502(a)(2)⁸⁶ provides that a participant or beneficiary (in addition to the Secretary of Labor or an ERISA-plan fiduciary) may bring an action for “appropriate relief” under section 409.⁸⁷ Section 409 provides that an ERISA-plan fiduciary who breaches any obligation under the Act “shall be personally liable to make good to such plan” any resulting losses and to restore to the plan any profits made through use of plan assets, and “shall be subject to such other

⁷⁹ 29 U.S.C. § 1132(a).

⁸⁰ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

⁸¹ 29 U.S.C. § 1132(a)(1)(B).

⁸² *Id.* § 1132(a)(2).

⁸³ *Id.* § 1132(a)(3). Other subsections of § 502(a) empower participants or beneficiaries to bring actions for failures to provide required information. *See id.* §§ 1132(a)(1)(A), (a)(4).

⁸⁴ *Id.* § 1132(a)(1)(B).

⁸⁵ *See, e.g., Harsch v. Eisenberg*, 956 F.2d 651, 654–56, 660–61 (7th Cir.), *cert. denied*, 113 S. Ct. 61 (1992).

⁸⁶ 29 U.S.C. § 1132(a)(2).

⁸⁷ *Id.* § 1109.

equitable or remedial relief as the court may deem appropriate.”⁸⁸ The scope of this section was addressed by the Supreme Court in *Massachusetts Mutual Life Insurance Co. v. Russell*.⁸⁹

In *Russell*, the claimant sought compensatory and punitive damages for improper and untimely processing of a disability claim. The Court unanimously held that such damages were not available under section 502(a)(2) to enforce section 409 because section 409 was intended to provide remedies to protect the entire plan rather than the rights of individual beneficiaries.⁹⁰ Because the claimant relied exclusively on section 409, the Court had “no occasion to consider whether any other provision of ERISA authorizes recovery of extracontractual damages.”⁹¹ However, Justice Stevens, writing for the majority, went well beyond the narrow holding necessary to decide the case and suggested a general unavailability of extracontractual damages in actions by participants or beneficiaries.⁹² As discussed in the next Section, Justice Brennan, joined by Justices White, Marshall, and Blackmun, wrote separately to emphasize the narrow focus of the Court’s holding and to express a quite different view of the availability of extracontractual damages under other provisions of the Act.⁹³

C. Action for “Other Appropriate Equitable Relief”

Section 502(a)(3) provides that a participant, beneficiary, or fiduciary may bring an action “(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.”⁹⁴ The meaning of this provision has stirred considerable debate, but as currently construed, it has offered little in the way of additional remedies to ERISA-plan claimants.

The differing views of the scope of section 502(a)(3) initially were suggested in *Russell* by the majority opinion of Justice Stevens and the concurring opinion of Justice Brennan. The question is whether a plaintiff’s right “to obtain other appropriate equitable relief to redress [violations of

⁸⁸ *Id.*

⁸⁹ 473 U.S. 134 (1985).

⁹⁰ *Id.* at 142.

⁹¹ *Id.* at 139 n.5. Extracontractual damages mean “damages other than the payment of benefits owed under a plan.” *Howe v. Varity Corp.*, 36 F.3d 746, 754 (8th Cir. 1994).

⁹² See *Russell*, 473 U.S. at 146–48.

⁹³ See *id.* at 148–58 (Brennan, J., concurring).

⁹⁴ 29 U.S.C. § 1132(a)(3).

ERISA or an ERISA plan]"⁹⁵ empowers a court to fashion remedies beyond those expressly identified in section 502(a). In dicta that has had significant influence, Justice Stevens stated: "The six carefully integrated civil enforcement provisions found in § 502(a) . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."⁹⁶ Justice Stevens found "a stark absence" in the statute itself and in its legislative history of any indication that Congress intended to authorize the recovery of extracontractual damages.⁹⁷

Justice Brennan pointedly disagreed, saying:

[T]he Court's remarks about the constrictive judicial role in enforcing ERISA's remedial scheme are inaccurate insofar as Congress provided in § 502(a)(3) that beneficiaries could recover, in addition to the remedies explicitly set forth in that section, "other appropriate equitable relief . . . to redress" ERISA violations. Congress already had instructed that beneficiaries could recover benefits, obtain broad injunctive and declaratory relief for their own personal benefit or for the benefit of their plans, and secure attorney's fees, so this additional provision can only be read precisely as authorizing federal courts to "fine-tune" ERISA's remedial scheme.⁹⁸

Justice Brennan found from the legislative history that Congress intended federal courts "to develop federal common law in fashioning the additional 'appropriate equitable relief'"⁹⁹ and that Congress intended to engraft trust-law principles into the ERISA enforcement scheme.¹⁰⁰ He noted that trust-law

⁹⁵ *Id.* § 1132(a)(3)(B)(i).

⁹⁶ *Russell*, 473 U.S. at 146.

⁹⁷ *Id.* at 148.

⁹⁸ *Id.* at 155 (Brennan, J., concurring).

⁹⁹ *Id.* at 156 (Brennan, J., concurring). Justice Brennan cited the statement of Senator Javits, one of the two principal Senate sponsors of ERISA, that it was "intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Id.* (Brennan, J., concurring) (quoting 120 CONG. REC. 29,942 (1974)). He also quoted Senator Williams, the Act's other principal Senate sponsor, as emphasizing "that suits involving beneficiaries' rights 'will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act.'" *Id.* (Brennan, J., concurring) (quoting 120 CONG. REC. 29,933 (1974)). He added: "Section 301, of course, 'authorizes federal courts to fashion a body of federal law' . . . to be derived by 'looking at the policy of the legislation and fashioning a remedy that will effectuate that policy.'" *Id.* (Brennan, J., concurring) (quoting *Textile Workers v. Lincoln Mills*, 353 U.S. 448, 451 (1957)).

¹⁰⁰ *Id.* at 156-57 (Brennan, J., concurring).

remedies are equitable in nature and include monetary damages.¹⁰¹ Later Supreme Court cases have suggested that the courts are to develop a federal common law of rights and obligations under ERISA,¹⁰² and commentators have suggested that the language of section 502(a)(3) is compatible with trust-law damages principles that afford make-whole relief.¹⁰³ Moreover, a 1989 congressional report expressed the view that the legislative history of ERISA makes clear that Congress intended the courts to develop federal common law with respect to benefits plans, including appropriate remedies, even if they are not specifically mentioned in section 502(a).¹⁰⁴ With limited exceptions, however, the courts have declined to fashion federal common law remedies.¹⁰⁵

Faced with claims for a variety of damages in addition to benefits due under the terms of ERISA plans, the appellate courts ruling after *Russell* virtually without exception refused to award any form of consequential, compensatory, extracontractual, or punitive damages. In *Sokol v. Bernstein*,¹⁰⁶ an early and frequently cited decision, the Ninth Circuit Court of Appeals rejected a claim for damages to compensate emotional distress caused by arbitrary and capricious acts by an ERISA-plan trustee. After reviewing the

¹⁰¹ *Id.* at 154 n.10 (Brennan, J., concurring).

¹⁰² *See, e.g.,* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987).

¹⁰³ *See, e.g.,* Diane M. Sumoski, Note, *Participant and Beneficiary Remedies Under ERISA: Extracontractual and Punitive Damages After Massachusetts Mutual Life Ins. Co. v. Russell*, 71 CORNELL L. REV. 1014, 1027-36 (1986).

¹⁰⁴ H.R. REP. NO. 247, 101st Cong., 1st Sess. 55-56 (1989). The report said:

In cases in which . . . facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, the Committee intends the Federal courts to develop a Federal common law of remedies . . . including such remedies as the awarding of punitive and/or compensatory damages against the person responsible for the failure to pay claims in a timely manner.

Id. at 56.

¹⁰⁵ *See Carr & Liebross, supra* note 5, at 222-23. "All too often, the courts apply ERISA's minimum standards as though they are maximum standards and repeatedly fail to carry out their mandate to create appropriate rules of federal common law to provide remedies for obvious injustices." *Id.* For a careful discussion of the limited federal common law developed under ERISA and an exhortation that the courts "seize the opportunity to fill in ERISA's gaps," see Jayne E. Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 WASH. U. L.Q. 671 (1994). "Absent further congressional enactments, federal courts are the only protectors of participants who have been 'betrayed without a remedy.'" *Id.* at 723.

¹⁰⁶ 803 F.2d 532 (9th Cir. 1986).

difference of view between Justice Stevens and Justice Brennan in *Russell*, the court stated: "We hold that because of the rationale of *Russell*, and because of ERISA's structure and legislative history, § 502(a)(3) makes no provision for extracontractual damages, including damages for emotional distress."¹⁰⁷ Similarly, in *McRae v. Seafarers' Welfare Plan*,¹⁰⁸ the Eleventh Circuit Court of Appeals rejected claims for compensatory and consequential damages, including damages for emotional distress, humiliation, and injury to financial reputation based upon an ERISA plan's refusal to pay medical bills for a surgical procedure initially approved by the plan but then denied retroactively. Saying that *Russell* "has provided the framework and the guidelines for us to use in making this decision,"¹⁰⁹ the court held that extracontractual damages are not available under section 502(a)(3).¹¹⁰

In fact, the only circuit court case since *Russell* that has allowed extracontractual damages under section 502(a)(3) is *Warren v. Society National Bank*,¹¹¹ a narrow ruling in which the court permitted the plaintiff to seek monetary damages based on an ERISA-plan trustee's alleged failure to transfer assets properly, thereby causing a tax loss.¹¹² The panel majority attempted to distinguish the case from cases in which plaintiffs sought punitive or compensatory damages for consequential injuries such as emotional distress, saying that the decision "does not necessarily put us in conflict with the holdings of other courts of appeal that have disallowed extracontractual damages under section 502(a)(3)."¹¹³ However, a dissenting judge noted that the majority did not cite a single ERISA case holding that extracontractual compensatory damages were recoverable under section 502(a)(3).¹¹⁴

The Supreme Court, in *Mertens v. Hewitt Associates*,¹¹⁵ has resolved negatively any question regarding the availability of extracontractual damages,

¹⁰⁷ *Id.* at 538.

¹⁰⁸ 920 F.2d 819 (11th Cir. 1991).

¹⁰⁹ *Id.* at 821.

¹¹⁰ *Id.*; see also *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992); *Novak v. Andersen Corp.*, 962 F.2d 757 (8th Cir. 1992), *cert. denied*, 113 S. Ct. 2928 (1993); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied*, 113 S. Ct. 61 (1992); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *Bishop v. Osborn Transp., Inc.*, 838 F.2d 1173 (11th Cir.), *cert. denied*, 488 U.S. 832 (1988); *Powell v. Chesapeake & Potomac Tel. Co. of Va.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986).

¹¹¹ 905 F.2d 975 (6th Cir. 1990), *cert. denied*, 500 U.S. 952 (1991).

¹¹² *Id.* at 982.

¹¹³ *Id.*

¹¹⁴ *Id.* at 985 (Wellford, J., dissenting).

¹¹⁵ 113 S. Ct. 2063 (1993).

albeit by a five to four margin.¹¹⁶ In an opinion by Justice Scalia, the majority in *Mertens* held that "appropriate equitable relief" in section 502(a)(3) is limited to remedies that were "typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)."¹¹⁷ According to the majority, reading the statute differently would render the word "equitable" superfluous.¹¹⁸

Justice White, joined by the Chief Justice and Justices Stevens and O'Connor, dissented, urging that equitable remedies available to a trust beneficiary traditionally included compensatory damages and that section 502(a)(3)'s reference to "appropriate equitable relief" encompassed "what was equity's routine remedy for such breaches—a compensatory monetary award calculated to make the victims whole."¹¹⁹ The dissent also noted that construing the statute in this manner avoided the anomaly of interpreting ERISA so as to leave those whom Congress set out to protect with less protection than they enjoyed before ERISA was enacted.¹²⁰

Section 502(a)(3)(B) allows an action "to obtain *other* appropriate equitable relief to redress [any act or practice which violates any provision of this subchapter or the terms of the plan]."¹²¹ The construction given to this section by the courts denying that it authorizes extracontractual remedies either deprives section 502(a)(3)(B) of any meaning or renders it duplicative.¹²² Most courts, and now the Supreme Court in *Mertens*, have concluded that "other appropriate equitable relief" means "what it usually means—declaratory or injunctive relief."¹²³ But, as Justice Brennan made clear in *Russell*, Congress

¹¹⁶ *Mertens* concerned a claim against a nonfiduciary, but its holding would seem equally applicable to claims against fiduciaries such as benefits plan administrators. For an analysis of the impact of *Mertens*, see Steuart H. Thomsen & W. Mark Smith, *The Implications of Mertens v. Hewitt Associates for Future ERISA Litigation*, 29 TORT & INS. L.J. 129 (1993); Richard Rouco, Comment, *Available Remedies Under ERISA Section 502(a)*, 45 ALA. L. REV. 631, 656-68 (1994).

¹¹⁷ *Mertens*, 113 S. Ct. at 2069.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 2074 (White, J., dissenting).

¹²⁰ *Id.* (White, J., dissenting).

¹²¹ 29 U.S.C. § 1132(a)(3)(B)(i) (emphasis added).

¹²² For a carefully reasoned development of this view, see *Reid v. Gruntal & Co.*, 763 F. Supp. 672 (D. Me. 1991). As the court said: "The challenge of section 1132(a)(3) [§ 502(a)(3) of ERISA] is to ascertain how that provision is different from the other remedial provisions of section 1132(a)." *Id.* at 677. In *Reid*, the court found that claims of promissory estoppel were included among the causes of action permitted under § 502(a)(3) and held that consequential damages were available. *Id.* at 678-79.

¹²³ *Novak v. Andersen Corp.*, 962 F.2d 757, 760 (8th Cir. 1992); *Sokol v. Bernstein*, 803 F.2d 532, 538 (9th Cir. 1986).

authorized broad declaratory and injunctive relief elsewhere in section 502(a). In Justice Brennan's view, section 502(a)(3) must be read as authorizing other relief.¹²⁴ He outlined in *Russell* the contours of the relief that courts should allow and the principles that should guide them in fashioning such relief.¹²⁵

In *Howe v. Varsity Corp.*,¹²⁶ an important recent case, the court expressed agreement with Justice Brennan's reasoning in *Russell*.¹²⁷ In *Howe*, the court endeavored to fashion a remedy for conduct by ERISA-plan fiduciaries that was "nothing more than a brilliant manipulative effort" to relieve a financially strapped company of burdensome retiree benefits obligations.¹²⁸ The court held that the plaintiffs, who had proven the defendants' breach of fiduciary duty under an ERISA plan, were entitled to monetary relief "in the nature of restitution to compensate them for benefits of which . . . they had been deprived."¹²⁹ The monetary relief that the court approved apparently included not only the value of benefits that the plaintiffs had been denied under the plan, but also amounts spent by the plaintiffs for replacement health insurance policies when their plan benefits ceased.¹³⁰ However, in defining the relief available under section 502(a)(3), the court was clearly constrained by *Mertens* and other narrow ERISA precedents. Citing *Mertens* and *Novak v. Andersen Corp.*,¹³¹ the court reversed judgments for compensatory damages.¹³² Moreover, although the court called the defendants' conduct "egregious" and approved the finding of the district court that "[d]efendants' conduct . . . was willful, wanton, malicious, and in bad faith,"¹³³ the court denied the availability of punitive damages, stating: "Only equitable relief, as opposed to damages, is available under ERISA, and punitive damages are not, by any stretch of the imagination, equitable relief."¹³⁴

Cases like *Howe* may slightly enlarge the limits of "other appropriate equitable relief" under section 502(a)(3). However, the Supreme Court in

¹²⁴ *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 155 (1985) (Brennan, J., concurring).

¹²⁵ *Id.* at 157-58 (Brennan, J. concurring).

¹²⁶ 36 F.3d 746 (8th Cir. 1994).

¹²⁷ *Id.* at 755.

¹²⁸ *Id.* (quoting district court).

¹²⁹ *Id.* at 756.

¹³⁰ *Id.* at 757 (Hansen, J., dissenting). The dissenting judge said: "I have great difficulty in seeing those sums as 'restitution.' To me they are traditional consequential legal damages and unrecoverable under § 1132(a)(3)." *Id.* (Hansen, J., dissenting).

¹³¹ 962 F.2d 757 (8th Cir. 1992).

¹³² *Howe*, 36 F.3d at 756.

¹³³ *Id.* at 755. The district court also found that the defendants' conduct was "just such a maneuver" as ERISA was enacted to prevent. *Id.*

¹³⁴ *Id.* at 752 (citation omitted).

Mertens and virtually all other courts have rejected Justice Brennan's argument that section 502(a)(3) should be read as "authorizing federal courts to 'fine-tune' ERISA's remedial scheme."¹³⁵ Therefore, ERISA claimants are left without a basis for seeking any form of consequential, compensatory, or punitive damages, whether in actions based on state law or in actions under ERISA. No matter what delays or abuses they may suffer and no matter how harmful the consequences may be, ERISA claimants must content themselves with recovery solely of the amount of benefits originally due.

V. STANDARD AND SCOPE OF JUDICIAL PROCEEDINGS: DE NOVO OR JUDICIAL DEFERENCE TO DEFENDANTS?

Not only have the courts systematically narrowed and diminished the remedies available to ERISA-plan claimants, they have also established a standard of review and often limited the scope of review in ways inconsistent with the language and the purposes of ERISA.

A. *Standard of Review*

Conflict of interest almost always exists between ERISA benefits plans and benefits claimants. Incongruously, and with little regard for the language of ERISA, the courts initially adopted the arbitrary-and-capricious rule as the appropriate standard for review of benefits decisions by ERISA plan administrators. This made little sense, but the courts' more fundamental error, as discussed later,¹³⁶ was treating claimants' actions for benefits as judicial review proceedings.

1. *Standard Adopted from LMRA Cases*

ERISA does not set out a standard for judicial review of decisions by plan administrators.¹³⁷ In early ERISA cases, courts borrowed the arbitrary-and-capricious standard of review from cases reviewing decisions by administrators of pension plans set up under section 302(c)(5)¹³⁸ of the Labor Management Relations Act (LMRA).¹³⁹ When borrowing the LMRA standard of review,

¹³⁵ *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 155 (1985) (Brennan, J., concurring).

¹³⁶ See *infra* part V.A.3.

¹³⁷ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108-09 (1989).

¹³⁸ 29 U.S.C. § 186(c)(5) (1988).

¹³⁹ See, e.g., *Bruch*, 489 U.S. at 109; *Van Boxel v. Journal Co. Employees' Pension*

however, courts failed to account for a significant difference between LMRA plans and ERISA plans. In LMRA plans, which are joint employer-employee plans, the impartiality of the administrator has been assured,¹⁴⁰ and judicial deference to the administrator's decision makes sense. In ERISA plans, by contrast, because the impartiality of the administrator is not assured, there is no basis for deference to the administrator's decision. As one court stated: "[The arbitrary-and-capricious] standard was taken over for use in reviewing benefit denials under ERISA . . . apparently without the courts' noticing that employers often held the whip hand in ERISA trusts as they did not with the joint employer-union trust funds authorized by [the LMRA]."¹⁴¹

2. Firestone v. Bruch: *De Novo* or *Abuse of Discretion*?

Courts employed the arbitrary-and-capricious standard in ERISA cases virtually without exception until the Supreme Court addressed the matter in *Firestone Tire & Rubber Co. v. Bruch*.¹⁴² *Bruch* concerned the denial of severance pay benefits to a group of employees by Firestone, which was the administrator of an unfunded severance pay plan governed by ERISA.¹⁴³ The district court granted Firestone's motion for summary judgment, holding that Firestone's denial of severance pay was not arbitrary or capricious.¹⁴⁴ The Court of Appeals for the Third Circuit reversed, holding that when the employer is itself the administrator of an unfunded benefits plan, deference to

Trust, 836 F.2d 1048, 1052 (7th Cir. 1987).

¹⁴⁰ LMRA plans are joint employer-employee plans, with employers and employees equally represented in the administration of the plans, and with disputes resolved by neutrals. See 29 U.S.C. § 186(c)(5).

¹⁴¹ *Van Boxel*, 836 F.2d at 1052.

¹⁴² 489 U.S. 101 (1989). For a useful analysis of pre-*Bruch* decisions, see George L. Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 CATH. U. L. REV. 133 (1989). Before and after *Bruch*, the courts have employed differing terms for the deferential standard of review. Some courts equate the arbitrary-and-capricious and abuse-of-discretion standards; other courts distinguish them. See, e.g., *Kotrosits v. GATX Corp. Non-Contributory Pension Plan for Salaried Employees*, 757 F. Supp. 1434, 1453 n.6 (E.D. Pa. 1991). Fine distinctions between the different formulations of deferential review are not meaningful. What is important is the difference between deferential review and nondeferential *de novo* review. See, e.g., *Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1052 (7th Cir. 1987).

¹⁴³ *Bruch v. Firestone Tire & Rubber Co.*, 640 F. Supp. 519, 520-22 (E.D. Pa. 1986), *aff'd in part and rev'd in part*, 828 F.2d 134 (3d Cir. 1987), *aff'd in part and rev'd in part*, 489 U.S. 101 (1989).

¹⁴⁴ *Id.* at 521-26.

its decision is unwarranted because there is no assurance of impartiality.¹⁴⁵ The court concluded that the proper standard of review was *de novo*.¹⁴⁶ The Supreme Court agreed that *de novo* review was the proper standard of review but based its holding on a different analysis.¹⁴⁷

Limiting its discussion to the proper standard of review for actions challenging benefits eligibility determinations under section 502(a)(1)(B) of ERISA,¹⁴⁸ the Court first considered the application to ERISA of the arbitrary-and-capricious standard developed under the LMRA and concluded "that the *wholesale* importation of the arbitrary and capricious standard into ERISA is unwarranted."¹⁴⁹ The Court then held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."¹⁵⁰ The Court focused not, as the court of appeals had, on the conflict of interest or lack of impartiality on the part of the plan administrator, but simply on whether the plan gave the administrator discretionary authority.¹⁵¹ Noting that "ERISA abounds with the language and terminology of trust law,"¹⁵² the Court stated: "Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers."¹⁵³

Although *Bruch* requires *de novo* review of administrators' decisions in benefits plans that lack a grant of discretionary authority, the ruling serves primarily as an explicit instruction for plan administrators who wish to assure themselves of deferential judicial review. They need only amend their benefits plans to include comprehensive grants of discretionary authority.¹⁵⁴

¹⁴⁵ *Bruch*, 828 F.2d at 152-53.

¹⁴⁶ *Id.* at 137-45.

¹⁴⁷ *Bruch*, 489 U.S. at 108-15.

¹⁴⁸ 29 U.S.C. § 1132(a)(1)(B).

¹⁴⁹ *Bruch*, 489 U.S. at 109.

¹⁵⁰ *Id.* at 115.

¹⁵¹ *See id.*

¹⁵² *Id.* at 110.

¹⁵³ *Id.* at 111. "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not subject to control by the court except to prevent an abuse by the trustee of his discretion." *Id.* (quoting RESTATEMENT (SECOND) OF TRUSTS § 187 (1959)). The Court also said: "[W]hen trustees are in existence, and capable of acting, a court of equity will not interfere to control them in the exercise of a *discretion vested in them by the instrument* under which they act." *Id.* (quoting *Nichols v. Eaton*, 91 U.S. 716, 724-25 (1875)).

¹⁵⁴ *See, e.g.,* Michael S. Beaver, *The Standard of Review in ERISA Benefits Denial Cases After Firestone Tire and Rubber Co. v. Bruch: Revolution or Déjà Vu?*, 26 TORT & INS. L.J. 1, 1 (1990).

By holding that deferential review of ERISA benefits decisions turns on the particular language of a plan rather than questions of conflict of interest, bias, and lack of impartiality on the part of the plan administrator, *Bruch* seriously undermined the purpose of ERISA even as the Court affirmed that ERISA was intended “to promote the interests of employees and their beneficiaries in employee benefit plans.”¹⁵⁵

The relationship between a benefits claimant and a benefits plan administrator is not a neutral relationship. With very few exceptions, the plan administrator—whether the employer itself, a retained administrator of an employer-funded plan, or an insurance company—will have a financial interest in curtailing the payment of benefits, an interest often heightened in the current cost-conscious climate. The plan administrator will also typically have both knowledge of the plan’s terms and experience in developing claims under the plan far greater than that of a claimant. The plan administrator often will have the assistance of a medical department or a legal department, with skilled professionals available to aid in documenting denial of a claim. From the outset, a claimant is at a distinct disadvantage in developing a claim.

Judicial deference to the decision of a plan administrator sharply increases a claimant’s disadvantage. Because the court will consider only evidence that was brought before the administrator at the time of the administrator’s decision, the claimant’s lack of experience in developing a complete claim record can become pivotal. Because the court will give deference to the administrator’s decision if it is supported by substantial evidence, the decision will not be reversed even if a preponderance of evidence supports a contrary conclusion. Because the court will give deference to the administrator’s decision if it is reasonable, the administrator’s skill in documenting the basis for a decision may determine the outcome.¹⁵⁶

In deciding whether review of a benefits denial decision should be *de novo* or should give deference to the administrator’s decision, the Court in *Bruch*

¹⁵⁵ *Bruch*, 489 U.S. at 113 (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

¹⁵⁶ The deferential standard has been applied in countless cases, almost always with negative results for claimants. *See, e.g.*, *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120 (4th Cir. 1994); *Taft v. Equitable Life Assurance Soc’y*, 9 F.3d 1469 (9th Cir. 1993); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40 (3d Cir. 1993); *Sandoval v. Aetna Life & Casualty Ins. Co.*, 967 F.2d 377 (10th Cir. 1992); *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137 (11th Cir. 1989); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416, 420 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988). For a survey of post-*Bruch* decisions, see Noel C. Capps, Note, *Firestone Tire & Rubber Co. v. Bruch: Are Lower Courts Following the United States Supreme Court Decision in ERISA Benefit Determinations?*, 31 WASHBURN L.J. 280 (1992).

pointedly declined to rest its decision on the concern for impartiality that had guided the court of appeals.¹⁵⁷ Instead, the Court suggested only that conflict of interest "must be weighed as a 'facto[r]' in determining whether there is an abuse of discretion."¹⁵⁸ In the view of one commentator, relegating consideration of conflict of interest to "a subsidiary analysis within the framework of a deferential standard of review" has left the courts "free to give little or no weight to the existence of a conflict of interest in determining whether the administrator has acted reasonably."¹⁵⁹ As this commentator suggests, the existence of conflict of interest "is arguably a more compelling focus for determining the appropriate standard of review to be applied in denial of benefit cases."¹⁶⁰

Deference to decisions of plan administrators also enlarges the potential for unfairness in judicial review of retrospective denials of health care claims. At the time medical care is being given, most patients have little option but to follow the recommendations of their physicians. Patients and their physicians must make treatment decisions prospectively, often facing uncertainties about the nature of a medical problem, the appropriateness of particular diagnostic procedures, the best course of treatment, the length of time necessary for recovery, and the like. Claims for reimbursement, however, are generally reviewed retrospectively,¹⁶¹ and such claims may be denied, after the fact, by

¹⁵⁷ See *Bruch*, 489 U.S. at 115.

¹⁵⁸ *Id.* (quoting RESTATEMENT (SECOND) OF TRUSTS § 187, cmt. d (1959)). One court has attempted to develop "a coherent method for integrating factors such as self-interest into the legal standard for reviewing benefits determinations." *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). Noting that the fiduciary role of an insurance company "lies in perpetual conflict with its profit-making role as a business," *id.*, the court attempted to develop a framework within which application of the arbitrary-and-capricious standard of review is "shaped by the circumstances of the inherent conflict of interest." *Id.* at 1563. The court held:

[W]hen a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries.

Id. at 1566-67 (footnote omitted).

¹⁵⁹ W. Douglas Holdren, Comment, *Denial of Benefit Claims Under ERISA: The Rise and Fall of De Novo Review*, 36 VILL. L. REV. 1219, 1234 (1991).

¹⁶⁰ *Id.*

¹⁶¹ See, e.g., Richard M. Scheffler et al., *The Impact of Blue Cross and Blue Shield*

plan administrators concerned more about cost containment or standardized treatment norms than about the needs of particular patients. Retrospective review is inherently disadvantageous for health care claimants, and judicial deference to claim denials based on retrospective review unreasonably increases this disadvantage.

3. *An Action for Benefits, Not a Review Proceeding*

One commentator has cogently argued that the Supreme Court's fundamental error in *Bruch* was treating actions for benefits under section 502(a)(1)(B)¹⁶² of ERISA not as actions for benefits but as review proceedings.¹⁶³ By its terms, section 502(a)(1)(B) does not establish a review procedure but a right of action: "A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan"¹⁶⁴ The language of this provision might helpfully be compared to the very different language Congress has employed when establishing judicial review procedures.¹⁶⁵ Section 502(a)(1)(B) permits a claimant to bring a civil action *to recover benefits due*, *to enforce rights* under a plan, or *to clarify rights* to future benefits.¹⁶⁶ By contrast, for example, the Social Security Act permits a claimant to bring a civil action *to obtain review* of any final decision of the Secretary.¹⁶⁷ The type of proceeding plainly intended by the language of section 502(a)(1)(B) is a plenary action for determination of facts and rights, not a review proceeding for correction of errors below.¹⁶⁸ Only in review proceedings would deference to prior decisionmaking have any place. Yet in virtually all actions under section 502(a)(1)(B), the courts speak and act as though they were engaged in judicial review of administrative decisionmaking. In doing so, they regularly presume that deference should be given to the

Plan Utilization Management Programs, 1980-88, 28 INQUIRY 263, 266 (1991); Griner, *supra* note 78, at 884.

¹⁶² 29 U.S.C. § 1132(a)(1)(B).

¹⁶³ See Jay Conison, *Suits for Benefits Under ERISA*, 54 U. PITT. L. REV. 1, 57-58 (1992).

¹⁶⁴ 29 U.S.C. § 1132(a)(1)(B).

¹⁶⁵ See, e.g., 5 U.S.C. §§ 701-06 (1988) (judicial review of decisions under the Administrative Procedure Act); 42 U.S.C. § 405(g) (1988) (judicial review of decisions under the Social Security Act).

¹⁶⁶ 29 U.S.C. § 1132(a)(1)(B).

¹⁶⁷ 42 U.S.C. § 405(g).

¹⁶⁸ See Conison, *supra* note 163, at 57-58.

decisions of the employers, insurers, or plan administrators that have denied benefits and stand to gain from having done so. Presuming that deferential review should be accorded under such circumstances "has no tenable foundation."¹⁶⁹ In ERISA actions for benefits, "[t]he rule of deferential review . . . serves no apparent function other than to impede protection of employee benefit rights."¹⁷⁰ In section 502(a)(1)(B), Congress gave ERISA claimants a full-fledged remedy; by treating section 502(a)(1)(B) as providing for judicial review, the courts have taken claimants' remedy away.

4. Review of Factual Determinations

Since the decision of the Supreme Court in *Bruch*, disagreement has developed in the courts of appeals concerning the standard of review to be applied when decisions by ERISA-plan administrators turn on questions of fact rather than on interpretations of terms of the plans.¹⁷¹ In *Pierre v. Connecticut General Life Insurance Co.*,¹⁷² the Fifth Circuit Court of Appeals read *Bruch* as addressing only the standard of review in actions based on plan term interpretations, and held that for all factual determinations under ERISA plans, the abuse of discretion standard should apply.¹⁷³ Commenting that deference is

¹⁶⁹ *Id.* at 34.

¹⁷⁰ *Id.* at 60.

The rule of deferential review is an anachronism. It is an artifact of a different legal framework and it serves no apparent function other than to impede protection of employee benefit rights. Courts persist in adhering to it, not for good and thoughtful reasons, but simply because courts in prior cases adhered to it—still without good and thoughtful reasons.

Id.

¹⁷¹ Compare *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991) (holding that de novo standard of review, which is required when an ERISA plan does not grant discretionary authority to plan administrator, extends to decisions based on purely factual questions) with *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 932 F.2d 1552 (5th Cir.), *cert. denied*, 112 S. Ct. 453 (1991) (holding that abuse-of-discretion standard rather than de novo standard applies to review of decisions based upon factual determinations).

¹⁷² 932 F.2d 1552 (5th Cir.), *cert. denied*, 112 S. Ct. 453 (1991).

¹⁷³ *Id.* at 1562. Other courts have held similarly that ERISA-plan administrators' factual determinations are to be reviewed deferentially rather than de novo. See, e.g., *Barish v. United Mine Workers Health & Retirement Fund*, 753 F. Supp. 165, 168-69 (W.D. Pa. 1990); *Questech, Inc. v. Hartford Accident & Indem. Co.*, 713 F. Supp. 956, 962-63 (E.D. Va. 1989). Some courts have applied a de novo standard of review to

given to the factfinder in virtually all decisional review, the court said: "We see no reason here why the plan administrator, i.e., the trier of fact, should be placed in a different status."¹⁷⁴ The court also suggested that considerations of expediency support deference to factual determinations made by plan administrators. "The courts simply cannot supplant plan administrators, through *de novo* review, as resolvers of mundane and routine fact disputes."¹⁷⁵

The approach taken by the court in *Pierre* significantly reduces the availability of *de novo* review in ERISA-plan benefits cases. Claims for medical care, disability benefits, or life insurance benefits frequently turn on factual determinations that, far from being "mundane and routine," go to the heart of the controversy. Questions regarding medical necessity, medical causation, preexisting condition, cause of death, and the like are factual questions that are often much more important in the resolution of ERISA benefits claims than the construction of plan terms. *De novo* review is necessary to insure impartial examination of such central factual matters.

The Court of Appeals for the Third Circuit has rejected the Fifth Circuit's analysis in *Pierre*. In *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*,¹⁷⁶ the court disagreed with the notion that ERISA-plan administrators' factual determinations should be accorded deference, calling attention to the difference between ERISA-plan administrators and governmental agencies accorded deferential review because of acknowledged expertise.¹⁷⁷ The court held that an ERISA-plan administrator's decision based solely on factual determinations is to be reviewed *de novo*. The court said its ruling was consistent with *Bruch* and its emphasis on the goals of ERISA—to protect the interests of plan members and their beneficiaries.¹⁷⁸ With two Justices dissenting, the Supreme Court declined the opportunity to resolve the conflict

ERISA-plan administrators' factual determinations without addressing whether the *Bruch* holding applies to factual determinations as well as interpretations of plan terms. See, e.g., *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1214 (4th Cir. 1990); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989).

¹⁷⁴ *Pierre*, 932 F.2d at 1559.

¹⁷⁵ *Id.* The court is disingenuous in characterizing as "mundane and routine" the factual controversies that arise in health care, disability, life insurance, and other ERISA-plan cases. The factual controversies are often highly complex. See, e.g., *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993). *Quesinberry* was a dispute, not unusual, regarding an accidental death insurance policy. At trial, medical experts testified at length about the decedent's underlying condition and the cause of her death. *Id.* at 1020 & n.1. The facts set forth in the opinion make clear that the issues were far from mundane or routine. See *id.*

¹⁷⁶ 944 F.2d 1176 (3d Cir. 1991).

¹⁷⁷ *Id.* at 1183–84.

¹⁷⁸ *Id.* at 1184–85.

in the courts of appeals on whether courts must accord deference to all factual determinations by ERISA-plan administrators.¹⁷⁹

B. Scope of Review

Even when *Bruch* requires de novo review of an ERISA-plan benefits denial, some courts have limited the scope of review to evidence that was put before the plan administrator.¹⁸⁰ This limitation was imposed by the Sixth Circuit Court of Appeals in *Perry v. Simplicity Engineering*.¹⁸¹ In *Perry*, the court held that the de novo standard of review "does not mandate or permit the consideration of evidence not presented to the administrator."¹⁸² In the court's view, *Bruch* did not require a de novo hearing but only a de novo review of the administrator's decision.¹⁸³ The court feared that if courts received and considered evidence not presented to plan administrators, courts would become "substitute plan administrators."¹⁸⁴ In the court's view, such a procedure would frustrate the goal of prompt and inexpensive resolution of benefits claims under the ERISA scheme.¹⁸⁵

Limiting de novo review to evidence that was presented to the plan administrator has serious practical consequences for benefits claimants. Many factors interfere with claimants' opportunities to develop adequate records before plan administrators. During administrative processing of benefits claims, claimants will seldom be represented by counsel; plan administrators, on the other hand, will often have counsel available and will ordinarily delegate the

¹⁷⁹ *Pierre v. Connecticut Gen. Life Ins. Co./Life Ins. Co. of N. Am.*, 112 S. Ct. 453 (1991).

¹⁸⁰ See, e.g., *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990); *Questech, Inc. v. Hartford Accident & Indem. Co.*, 713 F. Supp. 956, 962 (E.D. Va. 1989). But see, e.g., *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789-90 (11th Cir. 1994); *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*, 944 F.2d 1176, 1184-85 (3d Cir. 1991); *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989). Courts have also limited review to evidence before the plan administrator in cases calling for application of the abuse-of-discretion standard of review. See, e.g., *Sandoval v. Aetna Life & Casualty Ins. Co.*, 967 F.2d 377, 380-81 (10th Cir. 1992); *Woolsey v. Marion Lab., Inc.*, 934 F.2d 1452, 1460 (10th Cir. 1991).

¹⁸¹ 900 F.2d 963 (6th Cir. 1990).

¹⁸² *Id.* at 967. In the words of another court: "[A] curtain falls when the fiduciary completes its review, and . . . the district court must evaluate the record as it was at the time of the decision." *Sandoval v. Aetna Life & Casualty Ins. Co.*, 967 F.2d 377, 381 (10th Cir. 1992) (citing *Perry*).

¹⁸³ *Perry*, 900 F.2d at 966.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 966-67.

development of claims to specialists in claims management or examination. Consequently, although claims managers will generally know precisely what issues require development, claimants will often have an incomplete or uncertain understanding of what the central issues are and what evidence should be submitted. In addition, claimants are frequently baffled by complicated claims forms or procedures, but these forms and procedures are the stock-in-trade of claims managers. Also, during the administrative processing of claims, claimants' abilities to develop full records are sometimes seriously affected by the stress and disruption of the illnesses, major medical procedures, or familial deaths that give rise to their claims.¹⁸⁶

When medical issues must be addressed, claimants' disadvantages are often exacerbated by the difficulties most lay people experience in trying to procure adequate medical evidence. A growing number of primary care physicians are so overburdened by cost-containment procedures or so "fed up with . . . second guessing" from administrators that they are unwilling or unable to supply their patients with any medical documentation.¹⁸⁷ Other

¹⁸⁶ "Patients and family members, already emotionally strained by the events of a serious illness, are often helpless to challenge a faceless bureaucracy." Scott R. Severns, *Ensuring the Integrity of the Decision-Making Process May Be Lawyers' Single Biggest Contribution to Health Care Reform*, NAT'L L.J., Feb. 7, 1994, at 35.

¹⁸⁷ See *Who Shall Be Healed?* (Thirteen/WNET television broadcast, Jan. 27, 1993). The intensity of many physicians' attitudes towards cost-containment procedures was revealed in the comments of two physicians—Gilbert Mudge, Jr., M.D., a cardiologist, and Arnold S. Relman, M.D., Editor in Chief Emeritus of the *New England Journal of Medicine*—in the television program *Who Shall Be Healed?*

GILBERT MUDGE, JR., M.D.: Get the insurance companies out of my hair. . . . I didn't go to medical school to spend 40% of my time talking to nonphysicians on the phone about trivial details that actually have nothing to do with patient care. I went to medical school to meet patients and to take care of patients.

. . . .

ARTHUR R. MILLER: He sounds mad.

. . . .

ARNOLD RELMAN, M.D.: And he's saying what almost every practicing physician in this country is now saying. And you'd better listen very carefully because the American medical profession is fed up with the kind of management and second guessing that they're being subjected to.

Id.; see also Lisa Belkin, *Sensing a Loss of Control, More Doctors Call It Quits*, N.Y. TIMES, Mar. 9, 1993, at A1, B2.

treating physicians—pressed for time, certain that a “note from the doctor” will be sufficient, and disinclined to be drawn into claims disputes—are often willing to submit only brief, conclusory reports. On the other hand, consultants retained by claims managers and medical experts employed full-time by plan administrators are likely to prepare longer, seemingly more reasoned reports, even though these nontreating consultants may have significantly less understanding of the relevant medical facts than do treating physicians. Moreover, regularly employed or frequently retained experts may be biased in favor of those who employ them.

Finally, during the administrative processing of claims, records before plan administrators remain under the administrators’ control. Claimants do not generally know what is contained in the records until they become available through discovery procedures in civil actions; consequently, claimants may not become aware of the need to present additional evidence until after court proceedings have commenced.

Developing an adequate evidentiary record in a health care, disability, or life insurance case is a complex task, one performed poorly by many attorneys, let alone lay people acting under duress of illness or family loss. The range of issues that must be assessed and documented is daunting. Extensive knowledge and skills are necessary to understand the issues and develop a complete record.¹⁸⁸ Claims handlers employed by insurers and plan administrators have

[Dr. Warren Glaser, an internist for nearly twenty years,] closed his office, he said, because he was constantly justifying his decisions to insurance companies and Federal Medicare clerks. “It’s terribly aggravating and annoying,” he said. “It’s an affront every single day. I like to think that I practice good medicine, and to have someone second-guess you all the time wears you down.”

Id.; see also Barbara H. Warren et al., *Cost Containment and Quality of Life: An Experiment in Compassion for Physicians*, 151 ARCHIVES INTERNAL MED. 741 (1991).

[T]he demands [of managed care] can be overwhelming as auditors look over primary-care providers’ shoulders and third-party payers continue to increase their administrative requirements for monitoring of utilization and cost controls. The effect of managed-care policies on the “beleaguered physician” deserves attention. New medical trainees are avoiding primary care because of today’s pressures in this era of medical cost containment as the demands mount and the rewards seem less than adequate.

Id. at 741.

¹⁸⁸ See, e.g., RONALD R. GILBERT & J. DOUGLAS PETERS, SOCIAL SECURITY DISABILITY CLAIMS §§ 2:3--14, 4:3--9 (1993) (19 sections of a practitioner’s guide discussing obtaining medical evidence and developing the record in a Social Security disability claim); HARVEY L. MCCORMICK, SOCIAL SECURITY CLAIMS AND PROCEDURES

training and experience in developing claims records; lay claimants do not.

The *Perry* ruling does not take account of the practical obstacles that prevent most claimants from developing complete records before plan administrators. A better approach to de novo review is offered by the Eleventh Circuit Court of Appeals in *Moon v. American Home Assurance Co.*¹⁸⁹ The court in *Moon* concluded that limiting review to the evidence available to the plan administrator at the time of the benefits denial would be "contrary to the concept" of de novo review.¹⁹⁰

In more recent decisions, a number of courts have seemed to search for middle ground between *Perry* and *Moon*. In *Luby v. Teamsters Health, Welfare, & Pension Trust Funds*,¹⁹¹ the Third Circuit followed *Moon* and held that a court conducting de novo review of an ERISA decision is not limited to the evidence before the plan administrator.¹⁹² However, the court noted that its decision did not require a de novo evidentiary hearing or full trial if the record on review were sufficiently developed.¹⁹³

In *Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*,¹⁹⁴ Blue Cross denied an ERISA-plan claim on the basis that certain treatment was dental rather than medical in nature.¹⁹⁵ The district court received expert testimony regarding the nature and treatment of claimant's condition, temporomandibular joint dysfunction, to assist it in interpreting the terms of the plan.¹⁹⁶ The Second Circuit Court of Appeals approved the admission of expert testimony relevant to interpreting the terms of the plan, but suggested that even if the *Perry* rule were accepted, "evidence regarding the proper interpretation of the terms of the plan . . . would be treated differently from evidence intended to establish a particular historical fact regarding the claimant, like the evidence of the date of total disability at issue in *Perry*."¹⁹⁷

In *Quesinberry v. Life Insurance Co. of North America*,¹⁹⁸ the Fourth Circuit Court of Appeals sought to balance the multiple purposes of ERISA by

§§ 621-87 (4th ed. 1991) (67 sections of a practitioner's guide discussing evidence in a Social Security claim); ALAN BALSAM, M.D., & ALBERT P. ZABIN, *DISABILITY HANDBOOK* (1990 & Supp. 1993) (996-page book with 221-page supplement discussing evaluation and evidence of disability).

¹⁸⁹ 888 F.2d 86 (11th Cir. 1989).

¹⁹⁰ *Id.* at 89.

¹⁹¹ 944 F.2d 1176 (3d Cir. 1991).

¹⁹² *Id.* at 1184-85.

¹⁹³ *Id.* at 1185.

¹⁹⁴ 936 F.2d 98 (2d Cir. 1991).

¹⁹⁵ *Id.* at 100-01.

¹⁹⁶ *Id.* at 102.

¹⁹⁷ *Id.* at 104.

¹⁹⁸ 987 F.2d 1017 (4th Cir. 1993).

adopting a discretionary approach to scope of review.¹⁹⁹ The court noted the concerns expressed in *Bruch*, *Moon*, and *Luby* that ERISA be construed to protect the rights of employees and their beneficiaries and to afford no less protection than employees and beneficiaries had before ERISA's enactment.²⁰⁰ However, the court also emphasized the objectives identified in *Perry* and *Berry v. Ciba-Geigy Corp.*,²⁰¹ a pre-*Bruch* Fourth Circuit case. The latter objectives are to provide prompt resolution of claims and to prevent district courts from becoming substitute plan administrators.²⁰² In the court's view, these objectives warranted "significant restraints on the district court's ability to allow evidence beyond what was presented to the administrator."²⁰³ The court adopted a scope of review that gives the trial court discretion to receive evidence that was not before the plan administrator.²⁰⁴ However, the court narrowed the discretion to allow such evidence, stating that the trial court's discretion should be exercised "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision."²⁰⁵ In "most cases," according to the court, allowing additional evidence would not be appropriate.²⁰⁶

One commentator has proposed that rather than admitting or excluding new evidence, courts should remand benefits claims to ERISA-plan administrators for reconsideration.²⁰⁷ Among the arguments for this "liberal remand policy" are that it would reduce the burdens on the courts,²⁰⁸ would "utilize the practical strengths of plan administrators to develop evidence,"²⁰⁹ and would "help avoid 'adversarial litigation' in favor of private dispute resolution."²¹⁰

¹⁹⁹ *Id.* at 1026-27.

²⁰⁰ *Id.* at 1023-25.

²⁰¹ 761 F.2d 1003, 1007 (4th Cir. 1985).

²⁰² *Quesinberry*, 987 F.2d at 1025.

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Id.*; see also *Casey v. Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994) (in de novo review, the court "may limit the evidence to the record before the plan administrator, or it may permit the introduction of additional evidence necessary to enable it to make an informed and independent judgment"); *Donatelli v. Home Ins. Co.*, 992 F.2d 763, 765 (8th Cir. 1993) (in de novo review, the court may allow evidence not presented to the fiduciary but "should not exercise this discretion absent good cause to do so").

²⁰⁷ See Robert M. Hogg, Note, *The Evidentiary Scope of De Novo Review in ERISA Benefits Litigation After Firestone Tire & Rubber Co. v. Bruch*, 78 MINN. L. REV. 1575, 1601-06 (1994).

²⁰⁸ *Id.* at 1601.

²⁰⁹ *Id.* at 1606.

²¹⁰ *Id.* at 1602-03.

Although theoretically understandable, such an approach is misconceived because it ignores litigation realities. Remand for reconsideration is wholly unnecessary and from the claimant's perspective will virtually always be an exercise in futility. Remand is not necessary to give a plan administrator "an opportunity to reverse the decision denying benefits."²¹¹ An administrator who is willing to reconsider a benefits determination in light of additional evidence can do so at any time during the litigation process. What will in fact encourage a plan administrator to reconsider a denial of benefits or to offer a fair settlement is not remand but the approach of a firm trial date.²¹² In a process already stacked against claimants, a "liberal policy of remand" would give additional tactical advantage to insurers and administrators. Even if, in face of the contrary state of the law, a claimant manages to find an attorney and then, with effort and expense, commences to seek what ERISA promises—ready access to the federal courts and appropriate remedies²¹³—the claimant would face the new and unnecessary obstacle of remand, increasing the claimant's burdensome litigation costs, further delaying any prospect of impartial de novo review, and postponing the time when settlement might be possible. In all but the most unusual cases, remand for reconsideration would play into defendants' basic strategy—delay—while denying, as a practical matter, what plaintiffs seek—a day of reckoning.

Refinements of the *Perry* approach, like the *Perry* approach itself, may frustrate plaintiffs' ability to obtain full judicial review. Although limited allowance of new evidence as authorized by *Quesinberry* is preferable to complete refusal to receive such evidence as required by *Perry*, it nevertheless is inconsistent with de novo review to deny plaintiffs the opportunity to introduce evidence outside the administrative record when plaintiffs believe that this is necessary. Given the many practical disadvantages facing claimants during the development of the administrative record, de novo review on a fully developed record will not be assured unless plaintiffs have the right to offer new evidence. Review limited by the trial court's discretion to review of administrative records—records created and controlled by professional claims managers denying the claims of generally unrepresented lay persons—seems certain to perpetuate unfairness in many cases.²¹⁴

²¹¹ See *id.* at 1601.

²¹² It is a truism of settlement dynamics that defendants offer fair settlements not when they are shown evidence that supports or establishes plaintiffs' contentions but when litigation timetables give them financial incentive to settle.

²¹³ See 29 U.S.C. § 1001(b).

²¹⁴ Participants are often at a serious disadvantage when they question claims decisions. On their own, such participants must navigate the murky, frightening and often treacherous waters of the plan's claims procedures, usually without either an up-

*Southern Farm Bureau Life Insurance Co. v. Moore*²¹⁵ is an example of how far astray courts following *Pierre* and *Perry* have wandered from ERISA's stated purpose, "to protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by providing . . . ready access to the Federal courts."²¹⁶ *Moore* involved a claim for accidental death benefits under an ERISA-plan life insurance policy.²¹⁷ The central question in the case was a complex factual question—whether the decedent's death in an automobile collision and fire was caused or contributed to by a brain tumor. The beneficiary filed a claim for benefits with the plan administrator. After the plan administrator had conducted an investigation, the administrator proceeded directly to federal court without complying with ERISA requirements that notice of claim denial be given.²¹⁸ The required notice of denial should have provided "[t]he specific reason or reasons for the denial," "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary," and "[a]ppropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review."²¹⁹ At trial, the claimant presented expert medical testimony supporting her claim, and based on a jury verdict in her favor, the court entered judgment for the full policy amount.²²⁰ On appeal, however, the Fifth Circuit, following *Pierre*, held that the trial court had erred in reviewing the plan administrator's decision de novo and in receiving evidence that was not before the plan administrator when the decision to deny benefits was made.²²¹

A close reading of the court's statement of facts reveals that the "evidence that was before the plan administrator when he made his decision to deny benefits" was limited entirely to the evidence generated by the plan

to-date navigational chart or an experienced guide. In contrast, employers, plans, and insurance contractors have many advantages: first, they make the initial design choices and have the ongoing ability to alter the plan; second, they create the bureaucracy to administer the plan and therefore understand how to make the bureaucracy work for them; and third, they are supported by a well-paid flotilla of service providers and advisors.

H.R. REP. NO. 1023, 102d Cong., 2d Sess. 27 (1992).

²¹⁵ 993 F.2d 98 (5th Cir. 1993).

²¹⁶ 29 U.S.C. § 1001(b).

²¹⁷ *Moore*, 993 F.2d at 99–100.

²¹⁸ *Id.* ERISA requirements for notification to claimant of a decision are set forth at 29

C.F.R. §§ 2560.503-1(e)–(f) (1993).

²¹⁹ 29 C.F.R. § 2560.503-1(f) (1993).

²²⁰ *Moore*, 993 F.2d at 100.

²²¹ *Id.* at 100–02.

administrator's investigation.²²² The claimant's opportunity to submit evidence had been thwarted by the administrator's failure to follow ERISA regulations. Nevertheless, the appellate court refused to consider the evidence presented at trial by the claimant, holding in accord with *Pierre* that judicial review of a factual determination must be limited to the evidence available to the plan administrator.²²³ Moreover, the court conducted its review of the central issue in the case with deference to the determination of the plan administrator, the life insurance company denying the claim.²²⁴ In an ironic but meaningless concession to *Bruch*, the court held that it would consider evidence not before the administrator in reviewing de novo the administrator's "interpretation of the policy" but that there was no such evidence.²²⁵

The ruling in *Moore* exemplifies the assessment of one commentator: "The current law pays little attention to ERISA's central purpose of safeguarding benefit expectations. Indeed, it often seems perversely designed to thwart benefit expectations, for no better reason than judicial force of habit."²²⁶

C. Ready Access to the Federal Courts: An Unfulfilled Promise

In many ERISA opinions, federal judges have made clear that they do not consider federal courts well-suited to adjudicate ERISA health care and other benefits disputes.²²⁷ Some federal judges have expressed a certain disdain for what they characterize as routine, mundane matters raised by ERISA claims.²²⁸ Federal judges have commented on the "burgeoning" ERISA caseload.²²⁹ Moreover, the Judicial Conference of the United States, the principal policy making body of the federal judiciary, has expressed concern about clogging the

²²² *Id.* at 99–100.

²²³ *Id.* at 101–02.

²²⁴ *Id.*

²²⁵ *Id.* at 102.

²²⁶ Conison, *supra* note 163, at 3.

²²⁷ Some opinions suggest that judges were not meant to function as "substitute plan administrators." See, e.g., *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472 (9th Cir. 1993); *Pierre v. Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1559 (5th Cir.), *cert. denied*, 112 S. Ct. 453 (1991); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990). Opinions say that plan administrators are intended to have primary responsibility for claim processing. See, e.g., *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 394 (7th Cir. 1983). Other opinions suggest that plan administrators have advantages that the courts do not have: they are closer to the facts and the investigation of claims. See, e.g., *Pierre*, 932 F.2d at 1562.

²²⁸ See, e.g., *Pierre*, 932 F.2d at 1559.

²²⁹ See, e.g., *Crespo v. Candela Laser Corp.*, 780 F. Supp. 866, 867 (D. Mass. 1992).

federal courts with health care benefits disputes. The Judicial Conference has taken the position that such disputes should be resolved in administrative proceedings and then, if necessary, in state courts.²³⁰

The foregoing factors—joined, perhaps, with the judiciary's fear of "opening the floodgates"—have no doubt influenced the twenty-year transformation of ERISA from legislation intended to "promote the interests of employees and their beneficiaries in employee benefit plans"²³¹ and "protect contractually defined benefits,"²³² to an Act judicially construed to shield employers, insurers, and plan administrators. As already discussed, the federal courts have interpreted ERISA to preempt most state common law and regulatory protections for claimants²³³ while recognizing few federal remedies for claimants' damages, injuries, or losses;²³⁴ they have denied claimants make-whole relief and have barred punitive damages,²³⁵ even in cases of the

²³⁰ See Robert Pear, *U.S. Judges Warn of Health Lawsuits*, N.Y. TIMES, Aug. 16, 1994, at A13; Marianne Lavelle, *Judges Fear Health Care Suits*, NAT'L L.J., Aug. 29, 1994, at A6. "[The] Judicial Conference [called on] Congress to assure that the courts are a last and rare resort for patients who want to challenge denial or delay of benefits by their insurer" and said that "state courts—not federal courts—should be the primary forum for such disputes." *Id.* The concerns of the Judicial Conference were expressed in the context of national health care reform but are equally applicable to ERISA health care benefits cases.

To an important degree, the increase in ERISA cases docketed in the federal courts has been fostered by the courts themselves. Although ERISA establishes concurrent state and federal jurisdiction over ERISA benefits claims, *see* 29 U.S.C. § 1132(e)(1), virtually all such cases brought by plaintiffs in state courts are now removed by defendants seeking the accommodating procedures and results defendants are more likely to obtain in the federal courts. Review of the annotations to 29 U.S.C.A. § 1132(a)(1)(B) (West 1985 & Supp. 1994), the ERISA section allowing an action to recover benefits due under the terms of a plan, shows that almost all actions for benefits under ERISA are brought in or removed to federal court. Because ERISA preempts state common law claims, state actions that purport to raise only state law claims are "necessarily federal in character" and therefore removable to federal court under 28 U.S.C. § 1441(b). *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 67 (1987).

The burden of ERISA cases on the courts has also been increased by the absence of any impartial administrative review process applicable to ERISA benefits claims.

²³¹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90 (1983)).

²³² *Id.* (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)).

²³³ See *supra* part III.

²³⁴ See *supra* part IV.

²³⁵ See *supra* part IV.

most willful and outrageous conduct by defendants;²³⁶ they have insisted on treating ERISA cases as review proceedings rather than actions for enforcement of claimants' rights;²³⁷ they have adopted a rule of deference to the decisions of employers, insurers, and plan administrators,²³⁸ and have curtailed the scope of de novo review in the few cases allowing it;²³⁹ they have enforced procedural and evidentiary rules that weigh heavily against claimants;²⁴⁰ they have adopted an inapposite test that usually denies attorney's fees to prevailing plaintiffs.²⁴¹ It is impossible to read the minds of individual judges, and it is difficult to assess the effect of the judiciary's dissatisfaction with its role in adjudicating ERISA benefits claims, but, whatever the reasons, the effect of judicial construction of ERISA must be understood. Over twenty years, judicial decisions have stacked the deck against claimants and have severely limited the availability of the appropriate remedies, sanctions for wrongful conduct, and ready access to the federal courts that were promised by ERISA.

VI. REMEDIES FOR WRONGFUL CLAIMS DENIAL AND INSURER ABUSE

Three quite different approaches have been proposed for lessening the impact of the judicial decisions discussed in this Article. The most limited of these approaches is a simple amendment of ERISA to preserve state law remedies against insurers from preemption. A more comprehensive reform would amend ERISA to establish federal administrative procedures and judicial remedies for improper handling of benefits claims. A third approach, proposed as part of national health care reform, would limit the application of ERISA to health care plans and would establish within the framework of general health care legislation a new system of procedures, administrative hearings, and judicial review intended to protect health care claimants.

A. *Preserving State Law Remedies from Preemption*

An early legislative approach to restoring ERISA claimants' remedies was the effort to amend ERISA to make clear that damages actions against insurance companies based on state statutory or common law are not preempted

²³⁶ See, e.g., *Howe v. Varity Corp.*, 36 F.3d 746, 752, 755 (8th Cir. 1994).

²³⁷ See *supra* part V.A.3.

²³⁸ See *supra* part V.A.

²³⁹ See *supra* part V.B.

²⁴⁰ See *supra* part V.B.

²⁴¹ See *infra* part VI.B.5.

by ERISA. Senate Bill 794,²⁴² introduced in the 102d Congress, would have amended the ERISA preemption provisions to read:

[N]othing in this title shall be construed to relieve or exempt—

....

(ii) any insurance company from any provision of the statutory or common law of any State to the extent that such provision provides a remedy against insurance companies regarding such companies' practices in administering an employee benefit plan or in processing insurance claims thereunder.²⁴³

Among the advantages of this approach is that it respects the policy of preserving state regulation of insurance, a policy that arguably is reflected in the language of ERISA and is embodied in the McCarran-Ferguson Act. This approach also respects concepts of federalism in that it neither enlarges nor limits remedies against insurance companies available under state laws. This approach would protect against the overly broad application of federal preemption to state law issues like medical malpractice.²⁴⁴

Among the disadvantages of this approach are that it does not provide any remedy for unfair claims practices when the law of a particular state does not provide such a remedy, and that it does not provide any remedy at all against unfair practices by self-insured ERISA plans. This approach would also be criticized by those who view uniformity as a central principle of ERISA.²⁴⁵

B. *Establishing Federal Remedies Under ERISA*

The second approach to reform of ERISA is much more ambitious. House Bill 1881,²⁴⁶ the proposed Health Insurance Claims Fairness Act of 1993,²⁴⁷ would (1) add specific statutory time frames for processing ERISA welfare benefits claims; (2) provide for mediation to resolve disputed claims; (3) allow

²⁴² S. 794, 102d Cong., 1st Sess. (1991).

²⁴³ *Id.* § 1(a).

²⁴⁴ See *supra* text accompanying notes 74–78. For a discussion of the effects of ERISA on state common law liability and regulatory control of utilization review enterprises, see Kohler, *supra* note 13.

²⁴⁵ The Supreme Court emphasized this concern for uniformity in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 55–56 (1987).

²⁴⁶ H.R. 1881, 103d Cong., 1st Sess. (1993). H.R. 1881 is a revision of H.R. 1602, 102d Cong., 2d Sess. (1991), which had been introduced and amended in the previous Congress. H.R. REP. NO. 1023, 102d Cong., 2d Sess. (1992), to accompany H.R. 1602, offers much analysis applicable to H.R. 1881.

²⁴⁷ H.R. 1881 § 1.

a federal action for actual damages, including compensatory and consequential damages, caused by violation of ERISA or the terms of an ERISA plan; and (4) authorize judges to award punitive damages against certain parties in cases of fraud.²⁴⁸ This bill took an approach almost the opposite of Senate Bill 794 by creating federal remedies rather than saving state remedies from preemption. Detailed analysis of this lengthy bill is beyond the scope of this Article, but some attention should be given to several provisions of the bill.

1. *ADR Procedures*

The establishment of mediation procedures²⁴⁹ would provide a useful alternative for many claimants, helping in particular to resolve claims in which disputes are based on misunderstanding or absence of complete information.²⁵⁰ The bill would also require the Secretary of Labor to establish a Welfare Plan Claims Assistance Program.²⁵¹

2. *Amendment of Section 502(a)(1)(B)*

House Bill 1881 would make significant changes in section 502 of ERISA, the civil enforcement provisions. The bill would amend section 502(a)(1)(B)²⁵² by adding the following italicized language:

A civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan *or the provisions of this title*, to enforce his rights under the terms of his plan *or the provisions of this title*, or to clarify his rights to future benefits under the terms of the plan *or the*

²⁴⁸ H.R. REP. NO. 1023, *supra* note 246, at 15-16.

²⁴⁹ See H.R. 1881 § 3.

²⁵⁰ The House Report regarding H.R. 1602, the prior version of H.R. 1881, states:

H.R. 1602 establishes an early dispute resolution program so that many of the cases which today wind up in court might be more easily settled without resorting to litigation. Litigation is an expensive, time-consuming and often frustrating way to resolve disputes. Substantial barriers exist for participants in securing competent and reasonably priced legal assistance. Employers and plans would also benefit from avoiding litigation. Thus an early dispute resolution program holds the promise of substantial improvement over the current situation for both employers and participants.

H.R. REP. NO. 1023, *supra* note 246, at 29.

²⁵¹ See H.R. 1881 § 2(d).

²⁵² 29 U.S.C. § 1132(a)(1)(B).

*provisions of this title.”*²⁵³

Section 502(a)(1)(B) is the only provision of the ERISA enforcement scheme that allows actions to be brought in state or federal court.²⁵⁴ This amendment would therefore allow an ERISA claimant to bring an action to enforce the “provisions of this title,” including the provisions of the new subsection of section 502(c), discussed next, in state court, though subject to removal.²⁵⁵

3. Actual Damages

In the most important change to section 502, House Bill 1881 would add a new subsection 5 at the end of section 502(c).²⁵⁶ This new subsection would make the named fiduciary²⁵⁷ and any insurance contractor²⁵⁸ jointly and severally liable for “actual damages (including compensatory and consequential damages)” in any case in which a claim for welfare plan benefits is improperly processed or denied.

By providing a basis for compensatory relief, this provision would reverse the narrow construction that the courts have placed on ERISA enforcement

²⁵³ See H.R. 1881 § 4(b).

²⁵⁴ See 29 U.S.C. § 1132(e)(1).

²⁵⁵ See 28 U.S.C. § 1441 (1988).

²⁵⁶ H.R. 1881 § 4(a)(1). The new provision reads:

In any case in which a qualified welfare plan claim is denied in violation of the terms of the plan or of this title or in which any provision of this title is violated with respect to the administration of the plan in connection with such a claim or the processing of such a claim thereunder, the named fiduciary under the plan and any insurance contractor for the plan administering such claim shall be jointly and severally liable to any participant, beneficiary, employer, employee organization, or plan aggrieved by such failure or violation for actual damages (including compensatory and consequential damages proximately caused by such failure or violation), except that, subject to subparagraph (B), damages for such failure or violation shall not include punitive damages.

Id. The use of the phrase “such failure or violation” in two places in this subsection and again in subsection (B) is awkward. There is no “failure” to which “such failure” can refer. “[S]uch failure or violation” might better read simply “such violation.”

²⁵⁷ “Named fiduciary” would not include a named fiduciary under a multiemployer plan. See *id.*; see *infra* text accompanying notes 269–72.

²⁵⁸ “Insurance contractor” would be broadly defined to include an “insurer” (also broadly defined) who contracts to provide benefits or administer claims for benefits. See H.R. 1881 § 2(g).

actions²⁵⁹ and restore to ERISA claimants the possibility of obtaining adequate monetary relief for wrongful processing of claims. By allowing recovery of proven damages beyond the amount of the claim in dispute, this provision would help to restore balance between parties in ERISA benefits litigation and aid the resolution of claims by settlement.

4. Punitive Damages

The new damages provision also contains a limited authorization for an award of punitive damages against the named fiduciary or insurance contractor when the violation of the terms of a plan or of ERISA constitutes fraud.²⁶⁰ The decision to award punitive damages would be left to the discretion of the judge.²⁶¹ The committee report regarding House Bill 1602 (a prior version of House Bill 1881 introduced in the 102d Congress) states: "H.R. 1602 responds to the potential vacuum that may have been created by the preemption of state remedies under *Pilot Life* by providing a deterrent to bad faith behavior by plans and insurance contractors through the creation of a new ERISA remedy for fraud."²⁶²

²⁵⁹ See *supra* part IV.

²⁶⁰ H.R. 1881 § 4(a)(1) (proposed ERISA § 502(c)(5)(B)). "In any case in which a failure or violation described in subparagraph (A) constitutes fraud, each party liable under subparagraph (A) may, in the court's discretion, be liable to the plaintiff for punitive or exemplary damages in addition to damages described in subparagraph (A)." *Id.*

²⁶¹ *Id.* "Punitive or exemplary damages may also be awarded in cases of fraud. However, a judge (and not a jury) must decide whether punitive damages ought to be awarded after fraud is determined and, if so, the amount of those damages." H.R. REP. NO. 1023, *supra* note 246, at 31.

²⁶² H.R. REP. NO. 1023, *supra* note 246, at 30. The committee report states: "The Committee intends to rely on the definition of fraud taken from the model instructions to juries that Federal judges use." *Id.* at 31. One such pattern instruction reads:

Plaintiff's claim against the defendant has six essential elements, as follows:

First, that the defendant represented to the plaintiff that (*here set forth the alleged representation.*)

Second, that the representation was false;

Third, (that the representation was known by the defendant to be false when it was made) (that the defendant made the representation recklessly and without regard to its truth or falsity) (that defendant told the plaintiff that it had knowledge that the representation was true, while not having such knowledge);

Fourth, that the plaintiff relied on the representation and was deceived by it;

Fifth, that the plaintiff acted with ordinary prudence in relying on the representation, and

Specifying fraud as the basis for punitive damages is wrong. Fraud is a complex tort with an ancient history;²⁶³ moreover, it is notoriously difficult to prove.²⁶⁴ The appropriate basis for imposing punitive damages is bad faith, not fraud. The law of bad faith focuses on wrongful conduct in processing and settling claims and provides an extensive and well-developed body of law²⁶⁵ upon which judges could call, precisely the law that was nullified for ERISA claimants by *Pilot Life*.²⁶⁶ Fraud relates to a narrow range of deceitful conduct. Bad faith, by contrast, includes fraud but relates to a wider variety of abusive practices—excessive delay, inadequate investigation, failure to disclose claimant's rights, threats, exploitation of claimant's vulnerable position, unfair conditioning of settlement, forced litigation, retaliation, and so forth.²⁶⁷

House Bill 1881 would allow compensatory and punitive damages awards only against insurance contractors, as broadly defined,²⁶⁸ or the named fiduciary under a plan, and not against a named fiduciary under a multiemployer plan.²⁶⁹ Such damages would not be allowed against the ERISA plan itself,²⁷⁰ and this seems appropriate. However, exempting a named

Sixth, that the false representation was the proximate cause of injury to the plaintiff.

3 EDWARD J. DEVITT ET AL., FEDERAL JURY PRACTICE AND INSTRUCTIONS § 83.02 (1987).

²⁶³ See, e.g., W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §§ 105-10 (5th ed. 1984).

²⁶⁴ The difficulty in proving fraud comes primarily from the necessity of proving what is commonly called "scienter," i.e., knowledge or belief on the part of the defendant that a representation is false, combined with the intention to induce the plaintiff to act in reliance on the falsehood. See *id.* § 107. "The state of the speaker's mind, notwithstanding its elusiveness as a matter of psychology and its difficulty of proof, must be looked to in determining whether the action of deceit can be maintained." *Id.*

²⁶⁵ See, e.g., ASHLEY, *supra* note 31.

²⁶⁶ See *supra* part III.

²⁶⁷ ASHLEY, *supra* note 31, §§ 5:01-:22.

²⁶⁸ See H.R. 1881 § 2(g).

²⁶⁹ See *id.* § 4(a)(1).

²⁷⁰ Ordinarily, an ERISA benefit plan may be sued as an entity. See 29 U.S.C. § 1132(d)(1). Any judgment against a plan is ordinarily enforceable only against the plan. See *id.* § 1132(d)(2). The committee report accompanying H.R. 1602, the prior version of H.R. 1881, states:

[T]he Committee believes that section 502(a)(3)(B) of ERISA already authorizes courts to award actual damages designed to make the aggrieved individual whole when either the terms of the plan or the Act have been violated. In that respect, H.R. 1602 merely clarifies current law with respect to the remedies available for benefit claims.

fiduciary under a multiemployer plan from such damages does not seem justifiable. The named fiduciaries in multiemployer plans,²⁷¹ which are generally union-negotiated plans, are usually the members of a joint union-management board of trustees.²⁷² With respect to damages awards, named fiduciaries in such plans are in no different position than are named fiduciaries in any plan. The hazard of exempting named fiduciaries in multiemployer plans is that doing so might encourage the restructuring of single-employer ERISA plans simply to gain this exemption.

5. Attorney's Fees

House Bill 1881 would also make a helpful change in the ERISA provision for the award of attorney's fees. Currently, section 502(g)(1) of the Act provides that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."²⁷³ In determining whether to award fees, most courts have applied, at least nominally, a five-factor test first enunciated in *Eaves v. Penn.*²⁷⁴ This test was developed not to determine whether to award attorney's fees, but to determine whether fees should be awarded under the common-fund doctrine or assessed directly against the defendant.²⁷⁵ General application of the *Eaves* test in ERISA cases has been criticized as neither logical nor helpful.²⁷⁶ House Bill 1881 would mandate an award of attorney's fees and expert witness's fees to prevailing plaintiffs in welfare

H.R. REP. NO. 1023, *supra* note 246, at 30. (The report was drafted before the Supreme Court's decision in *Mertens v. Hewitt Associates*, 113 S. Ct. 2063 (1993). *See supra* notes 115-20 and accompanying text.)

Actual damages under § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B), which allows an action "to obtain other appropriate equitable relief . . . to redress [violations of ERISA or a plan]," would be enforceable against the plan. However, notwithstanding assertions in the committee report that actual damages are available under § 502(a)(3)(B), *see* H.R. REP. NO. 1023, *supra* note 246, at 22-23, 30, H.R. 1881 does not amend that specific section or amend any other section of the Act in a way that is likely to shake the nearly universal conviction of the courts that such damages are not available under § 502(a)(3)(B). *See supra* part IV.C.

²⁷¹ *See* 29 U.S.C. § 1002(37).

²⁷² *See generally* *Concrete Pipe & Prods. of Calif., Inc. v. Construction Laborers Pension Trust*, 113 S. Ct. 2264, 2271-74 (1993).

²⁷³ 29 U.S.C. § 1132(g)(1).

²⁷⁴ 587 F.2d 453, 464-65 (10th Cir. 1978). *See* Mark H. Berling, Note, *Attorney's Fees Under ERISA: When Is an Award Appropriate?*, 71 CORNELL L. REV. 1037, 1058-61 (1986) (citing cases).

²⁷⁵ *Eaves*, 587 F.2d at 465.

²⁷⁶ *See* Berling, *supra* note 274, at 1058-61.

benefits claims.²⁷⁷ The amendment would be more rational than the *Eaves* test, and it would also help to alleviate the considerable difficulty that ERISA claimants encounter in attempting to find representation.²⁷⁸

6. *De Novo Review*

A noteworthy and potentially troublesome omission from the amendments proposed by House Bill 1881 concerns the issue of *de novo* judicial review of ERISA benefits decisions. Although *Firestone Tire & Rubber Co. v. Bruch*²⁷⁹ requires that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator . . . discretionary authority,"²⁸⁰ the Supreme Court suggested in *Bruch*,²⁸¹ and virtually all lower courts have held, that when the benefits plan does give the administrator discretionary authority (as surely all but a dwindling number now do), the decisions of the administrator are to be reviewed under the deferential abuse-of-discretion or arbitrary-and-capricious standards. Moreover, some courts have held that all factual determinations are to be given deference, and other courts have held that all review is to be limited to evidence put before the administrator. Giving deference to decisions of plan administrators and limiting review to review on the administrators' records are unfair to ERISA-plan claimants.²⁸² Recognizing this, the House Committee on Education and Labor states in the report accompanying House Bill 1602, the prior version of House Bill 1881:

²⁷⁷ H.R. 1881 § 5(a)(3).

In any action or settlement proceeding under this title with respect to an employee welfare benefit plan by a participant or beneficiary under such plan in which the participant or beneficiary prevails or substantially prevails, the participant or beneficiary shall be entitled to reasonable attorney's fees and other costs of the action, including reasonable expert witness fees, to be paid by the opposing party. Fees to which the participant or beneficiary is entitled under this paragraph shall be at generally prevailing hourly rates.

Id.

²⁷⁸ See H.R. REP. NO. 1023, *supra* note 246, at 31-32. For an analysis of the benefits of mandatory awards of attorney's fees to prevailing plaintiffs, see Ann C. Bertino, *The Need for a Mandatory Award of Attorney's Fees for Prevailing Plaintiffs in ERISA Benefits Cases*, 41 CATH. U. L. REV. 871 (1992).

²⁷⁹ 489 U.S. 101 (1989). See discussion *supra* part V.A.2.

²⁸⁰ *Bruch*, 489 U.S. at 115.

²⁸¹ *Id.* at 111, 115.

²⁸² See *supra* part V.

In both types of adjudicatory proceedings (binding arbitration and civil litigation), the Committee intends the benefit claim denial to be reviewed de novo. In other words, the committee intends that the parties have the right to submit new evidence and that no deference be given to the factual findings and interpretations of plan terms by the decisionmaker below. Limiting the evidence to what was available to the plan administrator severely penalizes the participant who does not want or cannot afford to hire a lawyer to identify and obtain all relevant evidence during the earlier stages of review, and the Committee disagrees with decisions that limit de novo review to the record below.²⁸³

Although the committee report is clear, the import of the amendments proposed by House Bill 1881 is not clear. Nothing in House Bill 1881 makes clear a claimant's right to present new evidence and obtain de novo review in the courts. Resolution of these matters should not be left to interpretation of the legislative history, particularly because many courts have shown a preference for deferential review.²⁸⁴ Amendments to ERISA should authorize the submission of new evidence to the court and should require de novo proceedings in all cases.

C. Establishing Federal Remedies As Part of National Health Care Reform

Efforts to amend ERISA to protect the rights of benefits claimants were overtaken in the 103d Congress by efforts to enact national health care legislation. Several of the health care reform proposals introduced in Congress included provisions designed to protect claimants from wrongful claim denials, but for the most part, this issue was neglected while public and congressional debate focused on the cost, the sources of funding, the extent of coverage, and the appropriate structures for delivery of health care.

The most fully developed provisions for protecting health care claimants' rights were contained in the health care reform proposal presented by the Clinton administration.²⁸⁵ The Health Security Act, as initially proposed,

²⁸³ H.R. REP. NO. 1023, *supra* note 246, at 30 (citing with disapproval *Perry v. Simplicity Eng'g*, 900 F.2d 963 (6th Cir. 1990)).

²⁸⁴ *See supra* part V.A.

²⁸⁵ H.R. 3600, 103d Cong., 2d Sess. (1993); S. 1757, 103d Cong., 2d Sess. (1993). Several versions of the bills were introduced, and they are available in LEXIS, LEGIS Library, BLTEXT File. Citations are to the second version of H.R. 3600.

For valuable analysis of H.R. 3600, particularly with respect to procedural issues and appropriate review of claims, see Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60

would (1) establish uniform health plan claims procedures, including time limits for approval or denial of claims and procedures for review of denials at the plan level;²⁸⁶ (2) establish complaint review procedures under which aggrieved claimants could elect alternative dispute resolution, administrative hearings, or remedies available from courts of competent jurisdiction;²⁸⁷ (3) provide for review of administrative decisions by a national Health Plan Review Board and, if the amount in controversy exceeds \$10,000, in the United States courts of appeals;²⁸⁸ and (4) provide for assessment of substantial civil penalties for wrongful denial or delay of health care claims.²⁸⁹ Several aspects of the original Clinton health care proposal—House Bill 3600—are worthy of note.

1. *Claims Procedures*

House Bill 3600 would establish clear, uniform procedures for the approval, denial, and review of claims.²⁹⁰ The existing hodgepodge of differing and often vague claims and review procedures needlessly confuses most claimants and many health care providers.²⁹¹ Results are often inconsistent.²⁹² Procedural uniformity would benefit health care consumers.

The bill would also establish appropriate time limits for processing ordinary and urgent claims.²⁹³ Delay in deciding claims is one of the most common frustrations for claimants, often resulting in needless emotional harm and financial difficulty.²⁹⁴ Claims procedures and time limits would be

BROOK. L. REV. 105, 117-37 (1994); *Hearings Before the Subcomm. on Health and Environment of the House Subcomm. on Energy and Commerce*, 103d Cong., 2d Sess. (Jan. 31, 1994) (statement of Rand E. Rosenblatt, *On Access to Justice, Discrimination and Health Care Reform* (original text available in WESTLAW, 1994 WL 213576; revised text for the record, Feb. 14, 1994, on file with the *Ohio State Law Journal*)); Committee on Federal Legislation, *Procedural Issues in the 1994 Health Security Act*, 49 REC. ASS'N B. CITY N.Y. 450 (1994).

²⁸⁶ See H.R. 3600 § 5201.

²⁸⁷ See *id.* §§ 5202-04, 5211.

²⁸⁸ See *id.* § 5205.

²⁸⁹ See *id.* §§ 5206-07.

²⁹⁰ See *id.* § 5201.

²⁹¹ See Severns, *supra* note 186. "There is no uniformity in due process procedures from one health plan to the next, in state insurance laws, or in Medicaid procedures, which vary from state to state." *Id.*

²⁹² See, e.g., Robert Pear, *Medicare Claim May Be Rejected, It's Found, Depending on the State*, N.Y. TIMES, Mar. 29, 1994, at D23.

²⁹³ See H.R. 3600 §§ 5201(b)-(d).

²⁹⁴ Delay is a recognized basis for insurance bad faith claims. See ASHLEY, *supra* note

enforced by a simple expedient: when health plans fail to comply with procedures or time limits, claims are deemed approved.²⁹⁵ Specific reasons would be required for denial of claims.²⁹⁶ Review of claims would include review by a qualified physician if the resolution of any issues raised by a claim requires medical expertise.²⁹⁷ Taken together, the procedures for approval, denial, and review of claims are thoughtfully designed to facilitate fair, prompt, and understandable resolution of the majority of health care claims.

2. Grievances Based on Acts or Practices by Health Plans

House Bill 3600 would permit persons to file complaints in regional complaints review offices when they are aggrieved by any act or practice of any health plan that results in denial or delay of a claim.²⁹⁸ Complainants would have the opportunity (1) to take advantage of an "Early Resolution Program" (offering mediation and other forms of alternative dispute resolution);²⁹⁹ (2) to proceed with the complaint to an administrative hearing (with review by an appeals board and, if the amount in controversy exceeds \$10,000, the United States courts of appeals);³⁰⁰ or (3) in most cases, to forego administrative proceedings and rely on remedies available in court.³⁰¹ Attorney's fees and expert witness's fees could be recovered by prevailing complainants at the administrative level.³⁰² Legal and medical expertise is usually necessary to assure full development of contested claims, and such expertise is readily available to plan administrators. The fairness of the process is thus enhanced because prevailing claimants are able to be reimbursed for attorney and expert witness fees.

The flexibility of the complaint procedures set forth in House Bill 3600 is admirable. Most disputes, especially those arising from misunderstanding, should be resolved by the ADR procedures.³⁰³ More substantial disputes could be taken to administrative hearings or to court, at the complainants' option.

31, § 5:06.

²⁹⁵ See H.R. 3600 §§ 5201(b)(1), (c)(2).

²⁹⁶ See *id.* §§ 5201(b)(1), (e).

²⁹⁷ See *id.* § 5201(b)(4)(C).

²⁹⁸ See *id.* § 5202.

²⁹⁹ See *id.* §§ 5203(a)(2), 5211-15.

³⁰⁰ See *id.* §§ 5203(a)(3), 5204, 5205.

³⁰¹ See *id.* § 5203(a)(1).

³⁰² See *id.* §§ 5204(d)(2)(A)(iv), 5205(g).

³⁰³ See *id.* §§ 5211-15.

3. *De Novo Review*

Under House Bill 3600, review at the plan level and at administrative hearings would be de novo.³⁰⁴ The assurance of de novo review is important for claimants because, by contrast with professional claims administrators, claimants usually lack the knowledge or skill necessary to develop a fully documented claims record in the first instance.³⁰⁵ The bill does not address the scope of judicial review, however, and this is an unfortunate omission.³⁰⁶ Claimants should be permitted to submit all relevant evidence to courts, and court proceedings should be de novo in all cases.

4. *Compensatory and Consequential Damages*

Although House Bill 3600 would establish comprehensive procedures for dealing with wrongful claims, denials, and delays, it would assure only limited and in many cases uncertain remedies. At the administrative level, a hearing officer would have authority to order payment of benefits due and payment of prejudgment interest on the "actual costs incurred in obtaining the items and services at issue."³⁰⁷ However, the hearing officer would lack authority to award compensatory or consequential damages, even if bad faith denial or delay of a claim may have caused substantial harm to the claimant.³⁰⁸

Whether House Bill 3600 would make compensatory or consequential damages available in court raises complex questions regarding jurisdiction, exclusive remedy, ERISA exemption, and preemption of state law. Such damages clearly would be available in certain actions. Individuals would be afforded private rights of action to enforce the responsibilities of states, federal agencies, and regional or corporate alliances and could recover compensatory and punitive damages in such actions.³⁰⁹ Individuals could also recover compensatory and punitive damages from health plans for discrimination based on "race, national origin, sex, language, socio-economic status, age, disability, health status, or anticipated need for health services."³¹⁰ But the ability of individuals to recover compensatory, consequential, or punitive damages for

³⁰⁴ *Id.* § 5201(b)(4)(A). If the resolution of any issues requires medical expertise, reviews at the plan level would include review by a qualified physician. *Id.* § 5201(b)(4)(C).

³⁰⁵ See *supra* notes 186–88 and accompanying text.

³⁰⁶ See *supra* part V.B.

³⁰⁷ H.R. 3600 § 5204(d)(2).

³⁰⁸ The Secretary of Labor could assess substantial civil penalties against health plans for unreasonable denial or delay in the payment or provision of benefits. *Id.* § 5207.

³⁰⁹ See *id.* §§ 5235–37.

³¹⁰ *Id.* § 1402(c); see also *id.* § 5238.

wrongful delay or denial of claims against health plans, insurers, or plan administrators would be ruled out in some instances³¹¹ and in others would be subject to construction of uncertain provisions regarding exclusive relief, the application of ERISA, federal preemption, and the application of state law.³¹² The bill needs an unambiguous provision for state and federal jurisdiction to award compensatory and, if appropriate, punitive damages for wrongful denial of health care claims or abusive claims practices.

5. *Limited to Health Care Claims*

House Bill 3600 is universal health care legislation that would offer protection to employees and nonemployees for health care claims.³¹³ However, unlike House Bill 1881,³¹⁴ it would not offer protection to employees for other ERISA-plan benefits claims, such as disability, death benefits, or other employee benefits claims.

VII. THE ELEMENTS OF BASIC REFORM

Justice Doggett of the Texas Supreme Court has written about ERISA: "Through peculiar federal judicial interpretation, a statutory addition to workers' rights has been converted into a statutory removal of those rights. The law has been reshaped into a form that achieves the converse of its original purpose."³¹⁵ To restore one of ERISA's central purposes—protecting the

³¹¹ See *id.* § 5202(d). Administrative proceedings under §§ 5203 and 5204 of the bill would be the exclusive means of review of the acts or practices of a corporate alliance health plan. *Id.*

³¹² H.R. 3600 would permit a complainant to seek remedies available in courts of competent jurisdiction, except when the bill establishes the exclusive means of review. See *id.* § 5203(a)(1). H.R. 3600 also expressly provides that existing rights and remedies would not be preempted "except to the extent the right or remedy is inconsistent with this title." *Id.* § 5243. In a complex and ambiguous provision, H.R. 3600 also would amend ERISA to bring some health plans but not others under title I of ERISA and to make ERISA preemption rules apply to some health plans but not others. See *id.* § 8402. Applying H.R. 3600's provisions regarding exclusive remedies, nonpreemption of existing rights and remedies, and partial amendment of ERISA (including the ERISA preemption provision) in the already muddy context of prior ERISA preemption analysis would lead to anything but clear and certain remedies for claimants.

³¹³ See *id.* § 1001.

³¹⁴ See *supra* part VI.B.

³¹⁵ *Cathey v. Metropolitan Life Ins. Co.*, 805 S.W.2d 387, 392 (Tex. 1991) (Doggett, J., concurring), *cert. denied*, 501 U.S. 1232 (1991); see also Conison, *supra* note 163, at 62 ("The extent to which the law has developed without any consideration of ERISA's

interests of participants in employee benefits plans—the following basic reforms should be adopted.

1. Clear, uniform procedures should be required for the fair and timely deciding and plan-level review of claims.³¹⁶ Expedited procedures should apply to urgent claims. Review should include review by a qualified physician if resolution of issues requires medical expertise.³¹⁷

2. Notice of claim denials should be understandable; should set forth specific reasons for denial; should refer to plan provisions on which denial is based; and should describe any additional information or evidence necessary for approval of a claim, explaining why such additional information or evidence is necessary.³¹⁸

purposes, principles, language and legislative history is remarkable, and stands as paradigm of how federal courts should not develop common law.”); H.R. REP. NO. 1023, *supra* note 246, at 26 (“[C]urrent court interpretations of ERISA have removed disincentives to unfair claims practices and have weakened the ability of participants to enforce their rights under ERISA. As a result, the balance struck in ERISA between the competing interests of plan sponsors and participants has been upset.”).

³¹⁶ Experience with health maintenance organizations illustrates the importance of a clearly defined path to problem resolution. Many plans impose an ill-defined “grievance process,” others include arbitration clauses.

Due process in health care requires particular attention to promptness and access to information, including nonbiased expert opinion. These elements are almost universally lacking.

Severns, *supra* note 186; see also Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674 (1994).

³¹⁷ Increasingly, nonphysicians are second-guessing treating physicians in deciding claims or making managed care decisions. See *supra* note 187.

³¹⁸ Such notice is required by current regulations. See 29 C.F.R. § 2560.503-1(f) (1993); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 688–89 (7th Cir. 1992). However, compliance with the regulations is frequently lacking. The following form language from an ERISA-plan claim denial by Aetna Life Insurance Co. is typical:

Your plan provides benefits for services and supplies, but only if they are necessary for the treatment of an injury or disease. Based on the information provided, it appears this expense is not covered. Please let us know if there is additional information that should be brought to our attention.

Aetna Record at 143–76, *Schachner v. Connecticut Gen. Life Ins. Co.*, No. 89 Civ. 6403, 1992 WL 380912 (S.D.N.Y. Dec. 4, 1992) (evidentiary document containing numerous denial notices using identical generic language). This denial notice does not comply with the regulation because no “specific reason . . . for the denial” is set forth; no “[s]pecific

3. Alternative dispute resolution programs should be established to facilitate the early, informal resolution of disputed claims. Impartial administrative review procedures should be available to review claims that cannot be resolved informally. Such review should be quick and procedurally simple. Ombudsmen should be available to assist claimants, and hearing officers should be charged to develop adequate records.³¹⁹

4. Claimants' rights to bring an action in court to recover benefits or to enforce rights should be assured. Such actions should be treated as plenary actions for benefits, not as judicial review proceedings.³²⁰

5. Relevant additional evidence should be received at the administrative and judicial levels. Evidence must not be excluded merely because it was not offered at the initial stages of a claim by a lay claimant.³²¹

6. Deference to the interpretations or decisions of insurers or plan administrators is not appropriate. Such parties are not neutral or disinterested. All proceedings should be *de novo*.³²²

7. Courts should have jurisdiction to award compensatory damages when wrongful denial or delay of claims has caused provable harm. Punitive damages should be available when bad faith or outrageous conduct on the part of insurers or plan administrators is established.³²³

8. Reasonable attorney's fees and expert witness's fees should be awarded to prevailing plaintiffs.³²⁴

9. Claimants should have the same procedural and remedial rights under self-insured benefits plans as they have under insurance-based plans.³²⁵

10. Basic rights and safeguards should be established legislatively. Laws or regulations should require that plans be administered and benefits decisions be made in good faith, with due care, without undue delay, and without

reference to pertinent plan provisions" is made; no "description of any additional material or information necessary for the claimant to perfect the claim" is given; and there is no "explanation of why such material or information is necessary." See 29 C.F.R. § 2560.503-1(f) (1993).

³¹⁹ Effective use of ADR procedures and impartial administrative review procedures would give claimants timely, meaningful recourse when claims were disputed. Resort to litigation would be unnecessary in all but the most unusual cases.

³²⁰ See *supra* part V.A.3.

³²¹ See *supra* part V.B.

³²² See *supra* part V.

³²³ See H.R. REP. NO. 1023, *supra* note 246, at 27 ("[T]he lack of effective remedies for unfair claims practices means that ERISA does not provide the strong deterrence necessary to assure that claims are not denied because of gross negligence or willfull [sic] actions.").

³²⁴ See *supra* part VI.B.5.

³²⁵ See *supra* part III.C.

misrepresentation or other unfair practices. The courts should be charged specifically to develop a body of federal common law—drawing upon common law principles of contracts, torts, insurer bad faith, trusts, and remedies—defining rights and obligations under ERISA and assuring remedies for injustice.³²⁶

These reforms—none of them remarkable and all of them consistent with state law remedies that currently exist in many jurisdictions—would help restore fairness and integrity to the processing of health care, disability, and other employee benefits claims under ERISA.³²⁷

Opponents of reform argue that assuring claimants procedural fairness and meaningful remedies will have “destructive” effects on current managed-care practices.³²⁸ In the view of one commentator:

Taken together, the ERISA amendments—with the specter of punitive damages, deadlines that inhibit thorough investigations of claims, and broad

³²⁶ The Supreme Court has suggested that the courts are to develop a federal common law of rights and obligations under ERISA. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); *see also* Zanglein, *supra* note 105, at 723 (urging that federal courts “seize the opportunity to fill in ERISA’s gaps with federal common law”); Carr & Liebross, *supra* note 5.

³²⁷ Justice, in its procedural and substantive aspects, should be one of the fundamental measures of health care reform. *See* Lawrence O. Gostin, *Forward: Health Care Reform in the United States: The Presidential Task Force*, 19 AM. J.L. & MED. 1, 15–17 (1993).

A procedurally fair system would put in place impartial, speedy, and effective mechanisms for review of the grievances and complaints of consumers. Denials of care would not be unilateral decisions of non-physician managers, but would be subject to review at the initiative of the health care professional and/or patient. Alternative dispute resolution at the plan level, fair hearings at the health alliance level, and speedy access to the courts would all help assure a procedurally just system that respected the rights of informed consumers.

Lawrence O. Gostin, *Health Care Reform in the United States*, 21 J.L. MED. & ETHICS 6, 8–9 (1993).

³²⁸ *See, e.g.*, Robert Macaulay Jr., *Clinton’s Proposed Amendments to ERISA Threaten to Undo the Cost-Containment Gains Achieved Under Managed Care*, NAT’L L.J., Jan. 31, 1994, at 29; *see also* *Bills Relating to ERISA’s Preemption of Certain State Laws: Hearings on H.R. 1602 and H.R. 2782 Before the Subcomm. on Labor-Management Relations of the House Comm. on Education and Labor*, 102d Cong., 1st Sess. 92–93 (1991) (statement of James A. Dorsch). “It would be a serious public policy mistake to amend ERISA in such a way as to damage the ability to make . . . managed care decisions by hanging over the head of such decision makers a threat of a punitive damages award.” *Id.* at 93.

rights of appeal, including de novo hearings—would drop a wrecking ball on the managed-care procedures that health plans and employers have struggled to build during the last 10 years.³²⁹

Other opponents draw on the rhetoric of medical malpractice debate, arguing that ERISA reform will encourage “defensive claims practices,” akin in their view to “defensive medicine.”³³⁰ Health plans will be “sitting ducks for punitive damage awards,” and “popping noises from plaintiffs’ lawyers uncorking champagne bottles will echo across America.”³³¹

In truth, however, the opponents of ERISA reform seem primarily concerned about losing the multiple advantages accorded to employers, plan administrators, and insurers by judicial interpretation of ERISA. They oppose closing the “ERISA Umbrella,” which “offers a wealth of strategic advantages in defending insurers against claims of improper administration of employee benefit plans.”³³² They would like to continue operating in what has become “a regulation-free zone.”³³³ In opposing reform, they focus almost exclusively on issues of managed care, cost containment, and expediency; they largely ignore ERISA’s fundamental purpose: establishing standards of conduct, responsibility, and obligation for benefits plan administrators and protecting the interests of participants in employee benefits plans by providing appropriate remedies, sanctions, and ready access to the courts.³³⁴

³²⁹ Macaulay, *supra* note 328.

³³⁰ H.R. REP. NO. 1023, *supra* note 246, at 68 (minority views). “To avoid expensive litigation, it can be anticipated that plans and insurers will also begin paying questionable claims which would have previously been denied. New approaches to managing and controlling rapidly escalating health care costs will also be discouraged.” *Id.*

³³¹ Macaulay, *supra* note 328.

³³² Nolan & Bumgardner, *supra* note 6, at 25.

³³³ Widiss & Gostin, *supra* note 69, at 654–55 (“ERISA, adopted almost twenty years ago to protect employees, now allows employers to enter what is, in effect, a regulation-free zone.”).

³³⁴ See 29 U.S.C. § 1001(b).

For lawyers representing the consumers of health care, it is clear that the design of the problem resolution system will be one of the most critical elements of health care reform legislation. The Clinton plan for due process will undoubtedly draw fire from insurers, providers and states who see provisions for damages and attorney fees as a potential liability. Strong medicine is needed, however, to keep the process honest.

VIII. CONCLUSION

According to Stephen S. Ashley, an authority on insurance law:

A hundred years ago, insurance companies dwelt in a blessed state. An insurer, faced with the choice whether to settle a claim against its insured or to pay a claim of its insured, knew that if it refused to settle or pay, it would never have to spend more than the limits of its liability as set forth in the insurance policy, even if the insured filed suit against the insurer for breach of contract.³³⁵

Insurance companies underwriting ERISA benefits plans and administrators of self-insured plans dwell in that same blessed state today. Judicial construction of ERISA has assured them that they will never have to pay more than the amount of benefits originally due, no matter what abuses they might commit or what harm they might cause. Moreover, their decisions will be reviewed with deference by the courts, and often on a record limited to the evidence that they have assembled. ERISA was enacted to protect employees, and protection of employees with legitimate health care claims is needed more than ever in this period of aggressive cost containment by insurance companies and plan administrators. There is little hope for reversal in the trend of judicial decisions; legislative reform is required.

³³⁵ ASHLEY, *supra* note 31, § 1:01.